Community Health Education in Commonwealth Countries

Commonwealth Secretariat

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a study by
GILL WALT, Dip.Soc.Admin., B.Sc., Ph.D
and
PAMELA CONSTANTINIDES, BA(Hons), Ph.D
Evaluation and Planning Centre
London School of Hygiene and Tropical Medicine

Commonwealth Secretariat
Marlborough House, London SW1Y 5HX

The views expressed in this study are those of the consultants, and should not be taken necessarily to reflect those of the Commonwealth Secretariat.

Printed and published by
The Commonwealth Secretariat

May be purchased from
Commonwealth Secretariat Publications
Marlborough House
London SW1Y 5HX

ISBN 0 85092 238 0

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SUMMARY

This study was undertaken to collect information about community health education in Commonwealth countries, looking at activities and programmes relating to primary health care. Particular attention was paid to the role of the media, and to identifying programmes and projects that could be a stimulus to other countries.

A review of how the concept of community health education evolved historically suggests that it draws its roots from three broad areas, not easily distinguishable one from another: the field of health education of the public, changing foci in prevention, and the impetus from the primary health care approach, especially with regard to community participation. All Commonwealth countries claim to involve communities in health education although there are considerable qualitative and quantitative differences between countries. Responses to questionnaires suggested a gap between policy intent and implementation, stated preferences being for community participation in health education, but actual priority being given to the production of materials for health education.

From three case studies which looked in more depth at different ways countries are putting into effect community health education, it was clear that countries address different problems, and use quite varied strategies. It seems that community health education is a flexible and adaptable concept, involving people in action in very different ways. Tanzania reached a large number of villages through radio, listening groups, and group leaders; Sri Lanka linked families in villages with primary health services; and Cyprus took advantage of new medical technology to overcome public unwillingness to change traditional behaviour by shifting the emphasis of health education away from information to active prevention.

Although innovative community health projects were not easy to find, a few in Commonwealth countries are described, and others from other parts of the world are included. Some countries are breaking new ground in community health education, using an integrated approach, involving traditional healers in health education programmes, and experimenting with techniques like popular theatre, songs, and story-telling.

The review of the relationship between the mass media and community health education suggests that of all the media, radio is considered to have most potential, but that it works better as an educational tool when complemented by printed materials and different processes of interpersonal communication. One of the main considerations for health educators must be an understanding of the people they are trying to reach and the nature of the communication process.

Appendices to the study include a country-by-country description of community health education, and a selected annotated bibliography of useful references and resources.

INTRODUCTION

At the Sixth Commonwealth Health Ministers Meeting in Tanzania in 1980 it was decided that a study on community health education should be commissioned. It was noted at that meeting that "in order to achieve improvements in primary health care which is the key to raising health standards, the family must be educated and motivated to assume many responsibilities for its own health care. This can be achieved through a vigorous programme of health education ..." (p 40 of the Report).

2. The Commonwealth Secretariat approached the Evaluation and Planning Centre of the London School of Hygiene and Tropical Medicine to undertake the study, the objectives of which were:

(a) to collect information about national policy on community health education in Commonwealth countries;

(b) to collect information about community health education programmes and activities, including the use of the media, in Commonwealth countries;

(c) to identify policies, programmes and activities in community health education relating to primary health care and the health of families and individuals in that context;

(d) to identify policies, programmes and activities that are relevant to other countries and that would help them to develop their own community health education programmes.

3. This report contains the results of the study. It was carried out by Dr Gill Walt, assisted by Dr Pamela Constantinides, with the help of colleagues in the Evaluation and Planning Centre, especially Dr Carol MacCormack. Many other people were generous in giving time and support to the study. In particular, thanks go to Professor Sir Kenneth Stuart and Mr Keith Mather at the Commonwealth Secretariat, and to the many busy people in the countries visited who organised visits and interviews so efficiently and were always very helpful. Their names appear in an annex to this report. Finally, we are obliged to those people in ministries of health who filled in the questionnaire; replies were received from 43 of the 47 member countries of the Commonwealth.* This is a remarkable achievement for a postal questionnaire, and we are duly grateful to all those who responded so diligently.

* Of the 47 member countries, the Maldives became a special member only in July 1982, and so is not included in our analysis of data. However, four associated states or dependencies did complete questionnaires and have been included in the discussion.

How the study was done

4. The study started in October 1981. It was decided to use three approaches to collecting information. First, a search was made of the literature. In order to make a practicable task of a vast area, the criteria used in selecting relevant publications were that:

(a) they were about community health education or associated activities in Commonwealth countries, especially the less developed countries of the Commonwealth;

(b) although not to do with Commonwealth countries, they demonstrated activities or ideas which the Commonwealth might find useful;

(c) they illustrated positive or negative uses of the media in health education;

(d) they demonstrated imaginative and innovative approaches to community health education.

5. Second, three countries were visited to give more detailed approaches to different aspects of community health education. Cyprus, Sri Lanka and Tanzania all present alternative models of health education, and have special features that should be of interest to other Commonwealth countries. They are written up as separate case studies.

6. Third, a questionnaire was sent to the ministries of health of all Commonwealth countries in February 1982. By August 1982 over 90 per cent of member countries had filled in and returned the questionnaire. The analysis of this data forms the basis of the section of this report dealing with current activities, which gives detailed information on the countries that replied.

7. From all these sources it is possible to gain a picture of health education in the Commonwealth. In preparing this report the aim has been to provide a source of information that may be of practical use to health educators and policy-makers in the Commonwealth. For those who wish to pursue the more theoretical issues, the bibliography at the end provides references to follow up, or resource centres to turn to. The major aim of this report is to be itself a resource, and a practical guide to those concerned with community health education.

8. The study has focused on the less developed countries of the Commonwealth, although some examples of interesting programmes from the industrialised world have been included. The richer countries have far greater resources to spend on health education and they address different problems in relation to disease patterns. There is a vast amount of information available for these countries emanating from different disciplines such as psychology, sociology and education. Access to such information is limited for many of the less developed countries, and it was thought that the report would be more useful if it centred on the less privileged countries of the Commonwealth.

9. Before discussing the findings from our study there are several caveats which must be borne in mind. First, the questionnaires were sent to, and in most cases answered by, ministries of health. In the very large countries with states which have their own autonomous or relatively autonomous health education sectors, the national or federal ministry may not have been in the best position to fill in the questionnaire: certainly much of the finer details could be missing.* This is true, too, even of smaller countries, where ministries of health do not

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* This was well illustrated by the richness of detailed information supplied from Australia, where each state filled in the questionnaire. It enabled us to get a much clearer picture of health education in Australia as a whole.

always know what is going on in the non-government or voluntary sector but where, quite often, solid work or interesting experiments are undertaken. Finally, the subjectivity of the person who filled in the questionnaire cannot be ignored; the gap between intent and practice may not always have been explicit.

10. Second, while Commonwealth countries share a common link, they are a disparate and varied group. They range from among the world's richest and most industrialised to the poorest and least developed. Twelve of the countries have populations of less than one-quarter of a million. The patterns of disease differ enormously between the rich and poor, the developed and less developed, and therefore health education addresses different problems at the end of the continuum. Increasingly there are countries in the middle, however, that share some of the problems of both ends of the spectrum. Although the linking language is English, it is not necessarily so for the majority of people in all countries, and of course the cultural diversity between (and sometimes within) countries is enormous.

11. While these factors affect the analysis of the questionnaire, we should not be defeated by them. The cultural and historical heritage of the Commonwealth is a useful common denominator, and allows us to make generalisations that will be valid as policy guidelines. The opportunities for regional co-operation and exchange of ideas are great.

12. After this brief introduction we go on to consider how the concept of community health education evolved, in order to understand what it means. We then analyse what the countries of the Commonwealth themselves say about community health education activities, priorities and plans, and their use of mass media. Next we look at case studies of three countries each of which has focus on community health education in a different way. Several innovatory programmes, both inside and outside the Commonwealth, are then described, in the hope that these will be a stimulus to other countries. We go on to explore the issues pertaining to the use of the media in community health education, and the finally draw conclusions from the mass of information that has gone before. The last section of the report contains a selected bibliography of over thirty annotations and some useful addresses, which it is hoped will be a resource and a small reciprocation to all those health educators who took part in this study.

WHAT IS COMMUNITY HEALTH EDUCATION?

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

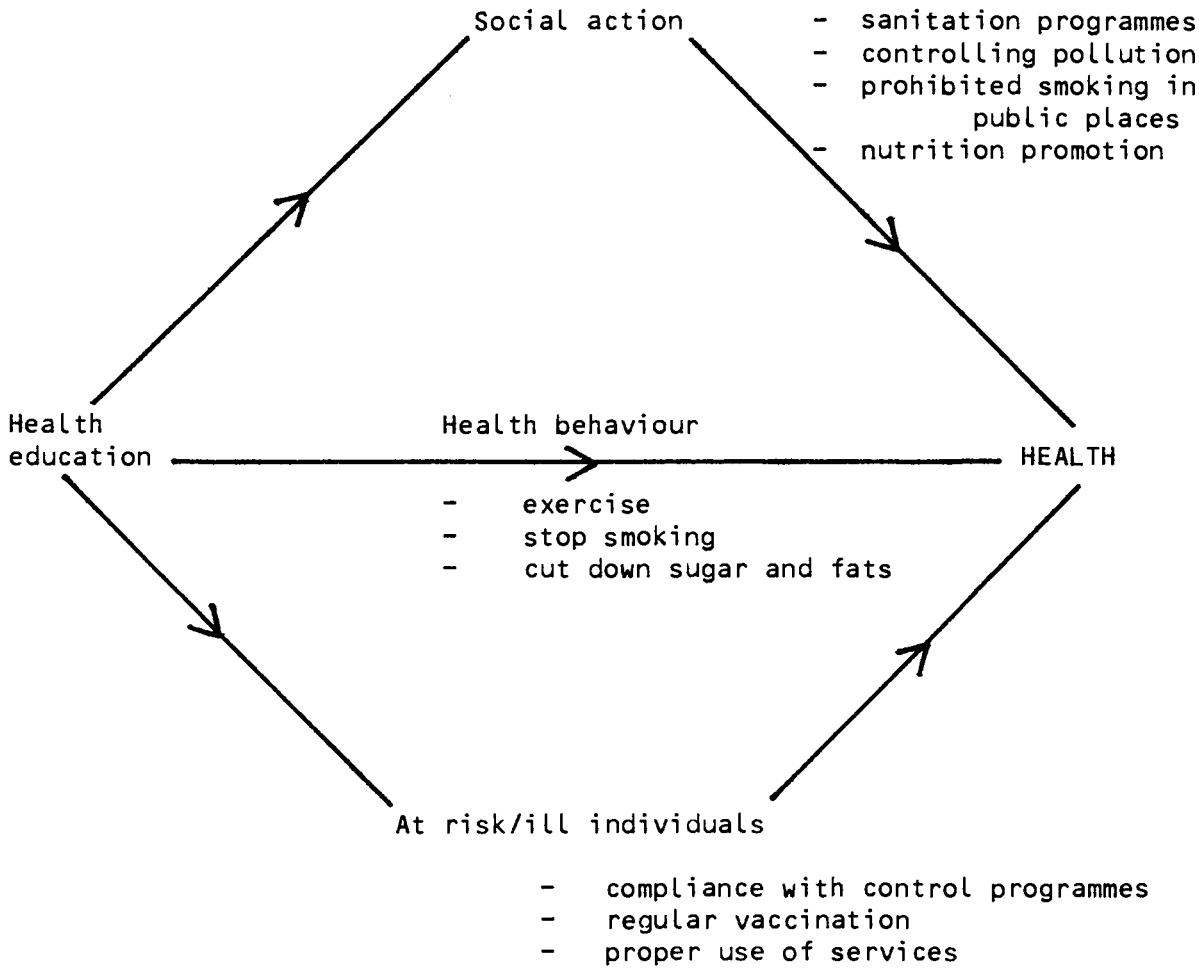
people campaigning for better health by changing their environment rather than, or as well as, changing individual behaviour.

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'etre 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 quality 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.

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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.

THREE CASE STUDIES

84. In this section we look in more detail at three countries chosen specifically because they have all involved communities in health education in very different ways. Tanzania ran a radio campaign called **Man is health**, with up to one million people participating in study groups and related activities. Sri Lanka is involving young volunteers to be catalysts in their villages, linking the community to the health services. Both are poor countries with disease patterns typical of social and economic under-development. Cyprus, on the other hand, is a relatively well-off middle-income country which has concentrated most of its health education effort on a particular disease, thalassaemia, which affects a high proportion of Cypriots, to try to help the community control its own health. While it may not be possible to generalise from three case studies, these countries do demonstrate the range of strategies open to the health educators who want to connect with the community.

TANZANIA: THE RADIO CAMPAIGN

85. In 1964 the United Republic of Tanzania was formed by the merger of Tanganyika (mainland Tanzania) and the islands of Zanzibar and Pemba close to the East African coast. Most of the population of Tanzania is rural, and was relatively dispersed until the programme of villagisation was introduced after 1967 and accelerated in the early 1970s. The grouping of people into **ujamaa** villages was part of the implementation of the Arusha Declaration of 1967, when President Nyerere committed the country to "Socialism and self-reliance". **Ujamaa**, loosely translated, means socialism. A salient objective of the Arusha Declaration was to promote rural development, giving priority to agriculture, health services, adequate wholesome water, and education.

86. The level of political organisation in the country is extensive. Recent figures suggest that about 12 million people now live in over 7000 villages. Each village is divided into cells of about ten houses, each cell with an elected leader. At the head of the village is an elected committee, with a chairman, and these committees are organised into higher bodies, all of which make up the ruling party, CCM (Chama cha Mapinduzi). While the original rationale of villagisation was to develop communal production and facilitate the provision of improved services, it has also been useful in concentrating people in administratively and politically accessible units.

87. A poor country, Tanzania has achieved much against many odds. Education, for example, has expanded enormously since the late 1960s. By 1980 some 70 per cent of the age group were enrolled in primary schools, and adult literacy had risen to over 60 per cent (World Bank, 1981). Although there are over 120 different tribal groupings in Tanzania, mostly of Bantu origin, it is rare among African countries in having one language, Swahili, which is understood and spoken by most people.

Health profile

88. Tanzania's gnp per capita is about US$260 (World Bank, 1981), which puts it among the world's low income countries. Ninety per cent of its 17.5 million people live in rural areas. Although there has been a small decrease in the infant mortality rate since 1967, it is still high at about 150 per 1000 (Ministry of Health, 1979). Life expectancy at birth is about 50 years for males and 52.5 for females. General nutritional states are low and few have access to clean water.

89. Health services are provided free by the Government (unlicensed private practice was banned from 1980), and parastatal organisations, voluntary agencies (mostly missions) and traditional practitioners also provide services. The organised health service begins at village-level health posts, and moves to rural dispensaries at ward level, and through divisions and regions to consultant and teaching hospitals at national level. Tanzania has paid particular attention to the training of appropriate personnel for each level of the health service.

90. The Ministry of Health is divided into three divisions: manpower development, hospital services and preventive services, each division headed by a director. Each region and district of the country is headed by a regional or district medical officer, who has some autonomy from the centre. After the Arusha Declaration the objective of national health policy was to extend comprehensive basic health services equitably to all within the limited available resources. This has been done by establishing a rural network of health posts, dispensaries and health centres, staffed by different levels of health workers (Ministry of Health, 1979).

Health education

91. The health education unit comes under the preventive health services division in the Ministry of Health, although it is situated in its own building within the Muhimbili medical centre complex in Dar es Salaam, the capital. It does not have its own budget, and it is noteworthy that in 1978/79 only 11 per cent of total health expenditure went on preventive services, which include health education (Ministry of Health, 1979, appendices).

92. The health education unit is staffed largely with nurses and former public health inspectors, now called health officers. Three or four of the latter have advanced diplomas in health education (from one-year courses in Nigeria or Lebanon). The lack of people trained in health education methods is felt to be a disadvantage; many health officers working at the district level have responsibility for health education but have had no special training in it.

93. The activities of the unit are hampered by the usual constraints of difficulties of transport and lack of financial resources. However, the media section of the unit is well-equipped, with an air-conditioned recording studio for radio programmes and printing and reproduction equipment for posters and leaflets. Activities in this area are fairly orthodox: special talks by medical experts, drama with health messages, some material for schools on radio. The exception is the **Mtu ni afya** (Man is health) campaign which will be discussed later. A number of leaflets and posters are produced regularly.

94. Health education takes place at the beginning of out-patient clinics, given usually by nurses in attendance. Much of the unit's work is giving health workers such as nurses short health education courses, so providing a wide network of educators. Some health information is aimed at groups of teachers, of religious organisations, of women's associations. These are usually talks and depend very much on the availability of personnel to give them, and the expressed interest of

groups in having such talks. Health educators also become involved in specific projects - environmental sanitation programmes, for example - where the health education component is considered to be vital to the success of the project. Several crisis campaigns related to disease control, especially cholera, have been co-ordinated by the health education unit.

95. Several health education seminars are given annually. One held in Arusha, for example, had the objective of preparing a booklet for leaders in villages, to give them information on health education in their villages. The subjects covered were varied, from environmental sanitation and nutritional questions to issues in community organisation. Other seminars are held, at district or regional levels, for teachers at training colleges or for maternal and child health aides, among others. A group is now working on a health curriculum to introduce into primary schools; this will be piloted in two districts before being nationally implemented.

96. While it may seem that the activities of the health education unit are quite limited, largely because of the scarce resources, this must be seen in the context of health policy as a whole. The overall purposes of health education are directed towards improving individuals' health and increasing self-reliance in maintaining it. Rather than promoting health education as the first step in self-reliance, government health policies instead have, for the most part, pursued the training of health workers for the practice of basic medicine in rural areas. The brief training being given to local health workers incorporates activities that would be recognised as health education, underlining the part people can play themselves. Also other institutions, such as the Tanzanian Food and Nutrition Centre, are involved in community education, although there may be much co-ordination at national level.

97. Health education, in other words, is integrated as far as possible into many facets of life; it does not remain the prerogative of the health education unit. One of the ways this has been achieved is through radio campaigns. Although only around 27 per cent of the population owned a radio in 1974, many more had access to a radio. In the last seven or so years radios have been produced in Tanzania, so this number is likely to have risen.

Mtu ni afya - Man is health

98. Stimulated by mass campaigns in such countries as Cuba and China, and by radio-listening forums in Canada, India, Ghana and other countries, Tanzania developed its own radio-listening groups in the mid-sixties (Hall, 1978). They started in a small way, largely from requests by villagers (school-leavers in particular) who wanted to continue learning but whose demands could not be met by the formal education system. Radio-listening groups were ideal in areas of illiteracy because they did not exclude those who could not read and write. Several useful lessons were learnt from the first campaigns - "The plan is to choose", "The choice is yours" and "Time for rejoicing" - but what was clear was that an impressive measure of success was achieved, with over 20,000 people in active groups. The enthusiasm among rural people in the wake of these programmes was evidence enough that the radio study group campaign as an approach to education warranted even greater efforts. Campaigns like these depended on forming small groups which would get together to listen to radio programmes. It was found that they needed some written material to support them, and a group leader to encourage discussion. Themes on relatively contained subjects were better than very broad programmes that tried to cover many themes.

99. The next theme to be chosen was community health, with an emphasis on prevention. The Ministry of Health underlined the fact that many of the common diseases people suffered from were susceptible to preventive measures. Also

health education could be closely linked with action, putting knowledge into practice. Furthermore, by the end of 1971 some 4,000 ujamaa villages existed (the **Man is health** campaign began in 1973) and the residents in these villages were already familiar with functional literacy classes and other adult education activities.

100. The three aims of the **Man is health** campaign were:

(a) to increase people's awareness of how they can make their lives healthier and to encourage both groups and individuals to take appropriate action;

(b) to provide clear and simple information about the symptoms of specific diseases and their prevention; and

(c) to encourage those who have participated in the national literacy campaign to maintain their skills by reading campaign materials designed especially for the newly literate.

The campaign thus depended on an immediate input from, and co-operation between, the Institute of Adult Education and the Ministries of Education, Health and Agriculture. Representatives from the party, CCM, and the Co-operative Union of Tanzania also participated in planning. This took a lengthy period - 16 months of intensive planning, production, distribution and training took place between the campaign initiation and the first radio broadcast in 1973.

101. First, materials such as textbooks had to be prepared and distributed. Health education posters, flipcharts, group leaders' manuals, study guides and "mock" radio programmes (cassettes) for use in group leader training were produced. These were all supporting materials for the actual radio programmes which were 12 in all - composed of 10 minutes "gathering-time" and 20 minutes study on a particular theme. A great deal of publicity was undertaken beforehand. It was seen as vital to inform government and political leaders about the campaign and the role they could play in it. A combination of political party support and active recruitment of adult education co-ordinators at the ward level was used to mobilise the general population. The slogan **Man is health** became part of the everyday vocabulary. Hall gives the example of one crowded bus, where friendly passengers were heard to shout "Open the windows! Mtu ni afya! we don't want to suffocate".

102. Radio spots and newspapers were used; and a unique publicity drive incorporated the design symbol of the campaign on the cloth traditionally worn by Tanzanian women. Five separate patterns were produced in the course of the campaign.

103. Previous experience had shown that a group leader plays a vital part in a successful group listening campaign. This **Man is health** campaign was thus built on the premises that local group leaders should be identified, and that they should receive some training beforehand. Since the target group was one million people, this meant that 75,000 study group leaders had to be trained. The aim was to have about one leader for a group of ten people. Each received a manual explaining his/her duties, methods of recruiting members and how to run meetings smoothly. Training occurred in three or four stages. Three-day seminars were held, and regional teams were trained to organise and conduct the next level of more local seminars. The seminars were run by tutors from the Institute of Adult Education and the health education unit, who supported those trained when they went into the field. The regional teams spread through Tanzania, and ran 70 district seminars.

104. The group leaders were chosen in a variety of ways. Some were chosen from among the prospective study group, but this was unusual since the groups

were not usually formed before a group leader had been trained; some were the ten-cell leaders - the political representatives in the villages. Others responded to publicity, and some - though not commonly - were selected by local adult education organisers.

105. The training seminars were the focus of several important campaign activities. Information about the campaign origins, aims and content was provided to motivate people to participate, and group leaders were trained through direct use of campaign materials. They were also taught how to use group learning methods and to differentiate between the formal didactic methods most had been accustomed to at school and the idea of a study group with equals working together. It was suggested in the study seminars that such groups leave behind a "monument" to the campaign, a physical structure or change that should stand in testimony to the group's participation in **Man is health.**

106. The actual campaign began on 14 May 1973. By the end of the sixteenth month of preparation, some 75,000 study groups had been trained, and were ready to lead the 12 weekly study meetings. The health campaign study groups were designed to progress logically from learning to action.

107. The campaign was not without its problems, of course. For some group leaders, a two or three days seminar was too short to grasp and understand all the material. Sometimes groups were much too large and discussion was stifled. Radio reception was occasionally poor. About half the time the groups had to do without the radio programme. Attendance in the districts with poor reception was lower than in other districts. In some districts there were not enough manuals, in others too many.

108. About 77 per cent of those who enrolled actually turned up, but there was a decline in attendance between the first and second weeks; the national average for the whole 12 weeks was 63 per cent. There was little difference in attendance between men and women. Many groups took up tasks suggested in the campaign materials; mosquito eradication practices, including clearing away bushes near houses, filling in stagnant pools or destroying containers with stagnant water, were common activities, as was building or repairing latrines. The response of groups varied from place to place, some displaying more imagination and initiative in their activities than others. The campaign organisers attempted to assess the success of the programme not only by looking at enrolment figures but also by testing how much knowledge was gained by study group participants and how many villagers adopted certain practices as a result of the campaign.

109. Four representative regions were selected, and questionnaires were administered at the beginning of the campaigns and at the end, to see if there was a growth in knowledge. An attempt was made to have control groups, but it was difficult to isolate communities who had not heard of the campaign. Of the people who participated in the study groups, it was clear that in nearly all cases there was a significant improvement in knowledge. In terms of health practices, the evaluation exercise was complex (it is difficult to measure a change in people's habits), and was applied in only eight chosen villages. All houses in the eight villages were checked for basic changes: vegetation having been cleared from the environs of the house, mosquito netting at the windows, the existence of a good standard latrine and other measures. The biggest changes were in elimination of vegetation and rubbish around the house, latrine usage and covers added to latrines. In all some 20 per cent of groups built latrines. A detailed discussion of the methodology and difficulties of evaluating the whole campaign is given in Hall.

Using radio campaigns and listening groups

110. There are several reasons why the **Man is health** campaign was successful in Tanzania. Villagisation meant that populations were concentrated and therefore accessible. The political organisation of the country greatly facilitated mobilisation and participation. The national language is understood by the majority of people. The radio network, although reception was poor in some areas, extended throughout the country. Essential institutional capacity existed to produce manuals and study guides, and an active adult education network with field staff also existed. Past experience helped the planners to avoid more obvious mistakes. The explicit ideological guidelines for the country's development made it clear that the campaign fitted in well with health policy and would receive strong political support. Finally, the campaign was well-supported with financial aid from overseas.

111. These conditions may or may not exist in other countries. How far this campaign could be replicated is not clear. However, one general conclusion that other countries must consider relates to the usefulness of expending enormous resources of time, personnel and finances on one programme. It can be claimed that **Man is health** was an expensive venture, especially for a one-off project. (However, other radio campaigns have taken place since - **Food is life** was one, on nutrition education, and another is planned on reforestation. The experience with the **Man is health** programme has benefited later campaigns.) After the twelfth radio programme, and the evaluation, the campaign was over. Given the time it took to plan, to produce materials and to train the study group leaders, however effective the campaign, it was costly.

112. One of the weaknesses, acknowledged at the time, was that too little thought was put into a continuing programme. The links between the campaign and the health services were not made strong enough. Campaign organisers accepted that a strong continuing impact of such a programme was possible only if permanent, active village health committees were linked to expanded primary health care services, with periodic mass campaigns on particular issues. The implication is that such campaigns have to be widely accepted by, and involve, all health workers and not only the members of the health education unit. While the initial campaign may need a large injection of resources, permanent connections with the organised health services should be built in, to ensure some continuity to health education activities.

Notes

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SRI LANKA: VOLUNTEERS LINK COMMUNITY AND PRIMARY HEALTH CARE

113. The Republic of Sri Lanka is situated in the Indian Ocean, a densely populated agricultural country with a population of nearly 15 million. The predominant ethnic group are Sinhalese, making up about 72 per cent of the population, and most are Buddhists. The Tamils make up about 20 per cent of the

population, and most are Hindus. Sinhala is the national language, but English is widely spoken, especially in urban areas.

114. Although Sri Lanka has a gnp per capita of about US$ 254 (Ministry of Health, 1980) which puts it amongst the poorest countries of the world, it has high life expectancy, low infant mortality and high literacy rates. These rates are considerably better than those of most low-income countries. It is generally agreed that these achievements are due to social policies initiated before independence but intensified and strengthened since then. Free education and health services, subsidised food, a reasonable communications network have all had their effects on the general well-being of Sri Lankans.

115. At the same time the country suffers from a hard core of poverty-related problems. Six per cent of Sri Lanka's pre-school children were estimated to be acutely malnourished in 1976. Increasing inflation, a worsening balance of payments, high unemployment are all taking their toll. The Government is now cutting expenditure on welfare policies like rice subsidies. It has also introduced several economic reforms, such as the liberalisation of import licensing and exchange controls, and making tax concessions to attract foreign private investments. The aim is to increase employment opportunities, stimulate domestic savings and investment and promote exports. The extent to which these ventures are being effective is not yet clear.

Health profile

116. The population of almost 15 million has features typical of many less developed countries. Population growth, however, is lower than in most developing countries, at 1.7 per cent per year, and life expectancy has increased markedly since the 1940s. Between 1946 and 1971 life expectancy of females rose from 41.5 to 66.9 years, of males from 43.8 to 64.0. Over the same period the overall death rate fell from 19.8 to 7.7 per 1000. Although there has been a dramatic fall in infant mortality rates, from 141 per 1000 live births in 1946 to 47 per 1000 in 1971 (and 37.1 in 1980), these are overall figures. Among certain groups the infant mortality rates are a good deal higher.

117. Health services are provided by the Government and privately, both sectors including Western and Ayurvedic medicine. According to out-patient utilisation figures, Western medicine is only slightly more favoured than Ayurvedic (West, 1981). There are estimated to be about 16,000 Ayurvedic practitioners, 10,000 of whom are registered and thus officially recognised. This is three times the number of physcians trained in Western medicine. The delivery of health care is through a network of institutions and health workers organised separately for preventive and curative services.

118. Preventive services are provided through the public health service. It is divided into 19 superintendent of health (SHS) divisions, each of which is then divided into health areas. At the head of each area is a medical officer of health (MOH) supported by a team made up of public health inspectors, public health midwives and public health nurses. Public health midwives are being re-trained and called family health workers who have broader functions than midwifery, but at present they both exist in most areas. They are the front-line workers who have closest contact with the community. In some areas they are assisted by health volunteers. Most maternal and child health (MCH) activities occur in the MOH areas, and it is the basic responsibility of the public health midwife or family health worker to link MCH clinics with the community.

119. The curative services, on which is spent the greater percentage of the budget, provide all in-patient and private care. Out-patient care is provided by central dispensaries at the periphery, through a variety of different level

institutions to the top teaching hospitals with specialised services. Most people live within five kilometres of a government health facility, even those in rural areas.

120. However, many of the peripheral-level units are by-passed by people in favour of larger institutions. Thus, for example, many small maternity hospitals are under-utilised, while urban maternity beds are over-utilised. Up to 80 per cent of births take place in institutions. Many people consult private practitioners, who are paid a fee for their service. The estate sector, comprising workers on tea, rubber and coconut plantations, was nationalised in 1974. Up till then, health services within their areas were the responsibility of the estate managers. Health status is low on the estates, and until government plans to improve facilities on them are carried out, it is likely to remain low.

121. Although the health service is described as free, it is not entirely so. A token charge is made for the first visit to out-patient facilities (0.25 rupees) and while in-patient care is free in the public wards of government hospitals, these hospitals all also have fee-charging wards. People also frequently pay privately for both Western and Ayurvedic treatment.

Health education

122. The health education bureau (HEB) used to come under environmental health, in the public health service sector of the Ministry of Health. In 1977, however, it was given independent status and is now a separate bureau, under the public health service sector, with an assistant director as its head.

123. The HEB is thus fairly autonomous. It has its own budget, is headed by a physician with a postgraduate degree in public health, and has four doctors with higher degrees in health education, one dentist and four health educators, all of whom are university graduates. It is worth emphasising that it is unusual in low-income countries to have so many well-qualified staff in health education. In Sri Lanka this is undoubtedly the result of the importance given to health education, and also the fruit of a free, universal education system. The HEB runs its own training programmes, both for health workers and for other sector workers like adult education or rural development officers, and it also provides its own professional training. People who wish to become health educators have to be graduates, and must have worked in the health field as, for instance, public health nurses. They attend a course in the HEB for about three months, and then work under supervision in the field. Later, most are sent abroad for postgraduate training in health education. The HEB runs such training courses only occasionally. The aim is to have one health educator in each of the 103 MOH areas. At present there are about 47 health educators.

124. Until recently the work of the HEB has followed conventional lines. Recognising the value of having the majority of the age-group in primary schools, health education has long been integrated into the school curriculum. A few years ago, however, on the initiative of the HEB and as a result of meetings with the Ministry of Education, health education teaching was incorporated into other subjects at primary school level (grades 1-5), although it remains a separate, examinable subject in grades 6-10. Teacher training includes health education, but the HEB also runs seminars to teach teachers the main aspects of health education; this further step has been taken to help teachers to identify health problems among children.

125. The school section of the HEB has also made attempts to strengthen links between schools and the community. Results of this sort of involvement include classrooms built by parents on money they have raised, and soup prepared and provided daily to children at mid-day. In one or two schools the community -

often mothers - come into the school for meetings, social gatherings, and sometimes for particular courses. Children come early to school, on a rota system, to clean the building and surrounds. In one particular school in an underprivileged suburb of Colombo, the teachers, pupils and a voluntary organisation carried out a survey of the parents in the vicinity, which helped to highlight some of the health problems of the area. For example it was discovered, even in this suburb of Colombo, that only 48 per cent of the parents had their own latrines. The dental education section runs dental clinics in some schools, where children are examined and receive some education regarding their oral health.

126. Community health education thus starts early in Sri Lanka, at primary school, and in many cases the community around the school has strong links through health activities. It is by no means uniform, however, and the HEB's enthusiasm is not always matched by active participation. Much depends on individual teachers.

127. The other traditional areas of health education are utilisation of the media, and hospital programmes. There are regular slots on the radio for health education - taking the form of a question and answer panel and "medical forum", a talk by a doctor. Newspapers also carry fairly regular features on different aspects of health education - often on specific diseases. As a large number of people have radios (60-70 per cent), and newspapers also reach even quite remote villages (80 per cent of the Sri Lanka population are literate), use of the media would seem to have a large potential. There has been some control of anti-health advertising: for example, advertising cigarettes has been banned on radio and television; baby milks on radio, television and newspapers; and alcohol on radio. Other material - posters, pamphlets and journals - is also produced periodically by the media section.

128. In hospitals, health education is part of the out-patient care but depends a great deal on the enthusiasm and ability of the staff. In some hospitals the move has been away from addressing large groups of waiting patients to giving small groups - or even two or three mothers, for example - a short talk on a particular topic. There are also special health education campaigns carried out by the HEB within the vertical disease control programmes of malaria, tuberculosis, filariasis, leprosy and sexually transmitted diseases. A recent addition was a cancer prevention project, aimed at educating the public especially in relation to oral cancer, which has the highest prevalence of all cancers. The HEB relies heavily on funds from the vertical programmes to make an educational input, which means that they are dependent on others who may or may not be sympathetic or enthusiastic about health education.

129. In summary, although the HEB's approach has been along conventional lines it has not been static. Attempts have been made to involve the community, to get away from simple information giving, to education involving people in the solution of health problems. The most exciting new approach in health education had been the move towards integrating health education into the primary health care system, with the help of volunteers. In this new community programme Sri Lanka could be providing a stimulating example to other Commonwealth countries.

Volunteer workers in community health education

130. The MOH areas are the preventive areas within which primary health care takes place. A typical MOH area (Padukka) has 145,000 population over a 101 square mile radius. Serving this area under the MOH are 8 public health inspectors, 3 public health nurses and 22 family health workers (formerly public health midwives). Many of the family health workers work with volunteers.

131. The HEB started a volunteer action programme a few years ago, to try to encourage village communities to control their own health. The village health committees with the family health workers choose volunteers whose tasks are promotive and preventive. Most of the volunteers are young people (largely women) who have finished school after 10-12 years of schooling. They are thus well-educated and are often extremely enthusiastic about being health volunteers. They receive some training for this locally, and are supervised by the family health workers.

132. The volunteer health workers do a variety of tasks. They may help in clinics, taking notes, perhaps weighing babies; they remind families to have their children immunised, perhaps accompanying the family to the health clinic. They try to stimulate the community to enlarge the local clinic, or to build latrines. They sometimes talk about family planning methods. In all villages they start with a situation report, and this acts as their base-line data. Thus they can test their effectiveness in the community over time, seeing how many more people have latrines and how many more children are immunised. Each volunteer takes responsibility for 15-20 families.

133. In the tea-growing area of Badulla one particular volunteer scheme has been a model for others. The public health midwife, a woman of great energy, helped in the setting up of a health committee. The president of this particular health committee is a respected Ayurvedic practitioner. Other members (from four villages) are the chief clerk in local government, the school principal, the rural development officer, a teacher, 3-4 farmers, 4 traders and a religious leader. Of the four villages of 1002 people one is almost all Muslim, the others are Buddhist. The volunteers (there were 34 at the start of the programme in 1978) did a situational survey of the villages, counting the number of households, the number of children under six, the number of couples in the age range 15-44 years, education levels and place of employment. They also checked on immunisation, latrines, whether drinking water was boiled, whether families had compost heaps, whether they were using birth control methods, whether they were receiving supplementary food for babies. The survey was repeated in 1980 and 1981, so that the volunteers could assess their work. Certainly they demonstrated that many more children had been immunised and latrines built. They had also, in the two years, started seven pre-school groups, run by themselves. Their work also involves home visiting and helping in clinics.

134. Why does this volunteer scheme work? The HEB and the volunteers recognise that there are barriers to their work in the community. They name illiteracy, alcoholism and poverty as constraints. Women are sometimes suspicious of young unmarried girls telling them about family planning. In spite of these difficulties, however, the volunteers have achieved much. They are themselves eager to be useful in the community. Indeed many say that the volunteers are part of a long tradition in Sri Lanka that goes back many years, much of which is based on the teachings of Buddha. Clearly, however, motivation is not all altruistic. There are very few employment opportunities for the young, even with good school-leaving qualifications. For a number of complex reasons the age of marriage in Sri Lanka has risen to an average age of 25 years, so there is a long interval between school and marriage. Getting accepted for training in any profession is also very competitive (and political-prospective candidates have to be supported by their local member of Parliament).

135. Finally, being health volunteers may be attractive, especially to young women. Because they are supervised by the family health worker, and receive a short local training, they have a certain status in the community. They can also legitimately move around that community, visiting homes in neighbouring villages, experiencing freedom from the usually rather restricted rural woman's position. For all these reasons, there are usually plenty of volunteer health workers; they are usually women (80 per cent) and between 18 and 25 years of age. When they stop being volunteers, it is frequently to get married, or to go for training, or because they have found a paid job. However, the situation varies over the country. Often the status of the family welfare worker is crucial to the community's acceptance of the health volunteers. If she is not respected, the scheme is not usually a success.

136. In some areas, such as the big development project of the Mahaweli dam, volunteers are being trained more narrowly, to help to control major diseases like malaria. They often succeed in getting villagers to agree to have their houses sprayed where the technical staff have failed, largely by taking time to explain and discuss with the families what this could mean to them.

137. Volunteer health workers are not all attached to the HEB. It is worth mentioning that there are many schemes in Sri Lanka using voluntary workers, embodying similar principles of using people's own potential, expanding services more widely and involving communities in controlling their own development.

138. One of the organisations doing this sort of work is the Sarvodaya Shramadana movement, a Buddhist voluntary association. Shrama means "energy and labour" and dana "sharing", so basic to the movement is the idea of co-operation, of self-help and of volunteering. Since 1975 they have trained 180 health workers who do not have a service function but act as a link between the community and the health services. These people are paid a very small amount, and some of the health volunteers trained by the HEB have also undergone training (of a few weeks) at the Sarvodaya Moratura training school. In this way they may earn a small amount of money. Sarvodaya is widely spread throughout Sri Lanka. Some 3,600 Sri Lanka villages are involved in Sarvodaya projects, and there are sister communities in Thailand, Guyana, Belgium, Holland, Norway, Switzerland and West Germany (Taylor, 1981). It is not without its critics, and all its projects have not been successful, but community kitchens have been started, water tanks built, and roads, schools and clinics erected with villagers' and volunteers' gifts of labour or shramadana.

139. Other projects based on similar principles include a UNICEF one to train health wardens in some of the slums of Colombo known euphemistically as "The Gardens". Some 56 males and 42 females received an eight-week training to become health wardens acting as catalysts between improved sanitation amenities and healthier lives (Adamson, 1982). For more information, see paragraph 201.

140. Sri Lanka thus has a well-developed health education programme which has been moving away from the more conventional health information model (providing information through posters, pamphlets, radio) towards the dynamic health education model where the aim is to change behaviour by involving people, giving them opportunities for reaction and participation. The health volunteer scheme is beginning to do just that.

Notes

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CYPRUS: THE SPECIAL CASE OF THALASSAEMIA

141. Geographically, the island of Cyprus stands almost midway between Europe and the developing countries of the Third World. Socially, politically, economically and in health terms, Cyprus has throughout this century been moving closer to conditions in Europe. Cyprus has not however escaped the political turbulence which accompanies its strategic position in the Eastern Mediterranean. After the 1974 coup and the subsequent Turkish invasion, approximately one-third of the island's population of some 634,000 are displaced persons in an island effectively partitioned by force of arms, with all the attendant problems this implies.

142. The significance of Cyprus to the rest of the Commonwealth is greater than its relatively small population would suggest. A history of emigration to the English-speaking world means that Australia, Britain, and Canada (and also America and South Africa) now have substantial minorities of Cypriot origin. Together with their entrepreneurial drive and work ethic, these Commonwealth citizens have brought health needs quite specific to their Mediterrean origin, due mainly to their relatively high rates of thalassaemia and glucose-6-phosphate dehydrogenase deficiency (G-6PD). How the Cypriot health services are dealing with these particular diseases and how they are educating their public on the nature and implications of genetically inherited haemoglobinopathies is therefore of more than theoretical interest to other members of the Commonwealth.

Who are the communities health education must reach?

143. This is a question increasingly complicated by the changing social, economic and political patterns of Cyprus today. The population is made up of several ethnic and religious groups. Apart from the Greek majority there is the substantial Turkish minority, and also Armenians and Maronites, all functioning within and across recent military and political divisions, in a context of increasing urbanisation.

144. At the beginning of this century the picture was clearer. A largely homogeneous rural population was scattered in discrete, named villages throughout the island: some Greek villages, some Turkish and a very large number ethnically mixed. Members belonged for life to the village into which they were born and they felt a strong sense of identity with it. To some extent this is still true. However, the urban population has been growing rapidly, rising to 42 per cent of the population in 1973. With the 1974 Turkish army invasion, substantial numbers of the affected rural populations took refuge in and around the towns, where they have been resettled as displaced persons. Now, for the first time, the urban population outnumbers the rural, being 53 per cent of the total. So at the moment Cyprus is made up of established urban conglomerates, settlements of displaced persons, and discrete village communities. Traditional patterns of social organisation have been shattered in some parts of the island and remain relatively intact in others. With increasing urbanisation , and the spread of urban influences into the villages, has come greater economic and social diversification.

145. Yet in spite of all this, and in spite of the political stress put on ethnic differences, the population of Cyprus remains remarkably culturally homogeneous. One systematically worked out and carefully evaluated set of health education techniques would have wide validity throughout the island.

Health profile

146. The general standard of health in Cyprus compares favourably with that of other countries in the Western world. Diseases which constituted major health problems at the beginning of the century have been either virtually eliminated or are under tight control. As the standard of living and education and medical services have steadily improved, so have the health indices. There has been an overall decline in the fertility rate, a marked increase in life expectancy at birth from 58 years in 1940 to 73 years in 1980, and an impressive drop in infant mortality from some 63 per 1,000 live births in 1950 to 17 per 1,000 in 1980. A successful immunisation programme linked to MCH services now means that an estimated 90 per cent of children are actively immunised against the communicable diseases of childhood. Taking private and government health services together, Cyprus now has one doctor for every 912 persons, one dentist for every 2,805 persons, one qualified nurse per 270, and 67.6 hospital beds per 10,000. The major causes of death place Cyprus firmly in the "advanced world" since these are accidents (a significant number of which are road accidents), cardiovascular diseases, and cancers. Several factors stand out as being of key significance in the relative success of Cyprus in the prevention and control of environmentally-based and communicable diseases.

147. First, Cyprus is a small island with a small population. Effective control of seaports and airports can create a type of "cordon sanitaire" vis-a-vis the outside world, while relatively small distances and an adequate road system make for ease of communication and access to existing health facilities. Second, there is fairly stringent control legislation, especially as regards continuing anti-malarial work, the anti-echinocciasis campaign and sewage disposal. Some of the legislation has continued from colonial times; other controls, such as the prohibition of cigarette advertising on TV and radio, are quite recent. Finally, and perhaps most important, has been the overall socio-economic development, especially the spread of free education. Elementary education was made compulsory for all children from 1960, with secondary education now also free for the first three years for children of both sexes.

Health education

148. In various forms, health information and education of the public has a long, if patchy, history in Cyprus. Some activity, like that accompanying the malaria eradication campaign, was merely designed to inform the public about the reasons behind steps such as spraying and swamp drainage which were to be enforced anyway. Other activity had a broader function. One of the early success stories is the campaign against favism.

149. Broad beans (vicia fava), fresh and dried, are a popular food source in Cyprus as throughout the Mediterranean, and are commonly grown in back yards and fields. But the sex-linked G-6PD deficiency means that a small proportion of the population (an estimated 10-20 per cent are homozygotes), particularly children, will display a severe, sometimes fatal, haemolytic anemia after ingesting the fresh broad bean. Since a few females as well as being carriers are also affected, a blanket exercise was set up to advise the public not to feed their infants and young children broad beans. The assistant health directors of the time arranged for regular radio broadcasts on the subject, in Turkish and Greek, and there was a drive to back this up with health talks and poster campaigns in

the schools, as well as with informal education in the villages by government health inspectors. The net result is that today, although the complex reasons for favism are probably still little understood by the general public, it has become part of popular folk practice that "you do not feed broad beans to young children".

150. Although such an early campaign is impossible to evaluate precisely, it is the impression of the older generation of paediatricians that whereas they would see perhaps 30-40 cases of favism in a year when they started their careers, they might now see 3 or 4, and these are often accidental - an unsupervised child picking and eating the growing bean. However, though favism is no longer considered to be a medical problem in Cyprus, the "overkill" nature of the campaign, plus a tendency for the younger generation to classify the advice as "old wives tales", suggests that a new and more detailed educational "refresher course" for the public is due.

151. Though Cyprus has over the past decades been moving successfully away from colonial-type paternalistic health advice to the public towards more modern concepts of health information and education, the movement is by no means complete. Nor, in the opinion of its practitioners, does health education yet have the recognition and financial baking at the highest level that it needs.

152. Although there is not as yet a special health education unit, the Director of Medical and Public Health Services of the Ministry of Health has himself studied health education in America. The health educators are sensitive to the relative neglect of health education in Cyprus, and aware of the current trends stressing the importance of health education. But, as is often the case, in the competition for government funds and for skilled personnel (Cyprus has a thriving and wealthy private health industry) health education has adopted something of a backstage role. However, in recent years the nucleus of a health education unit has been set up in the form of a regular departmental committee headed by one doctor with public health training and one public inspector. £5,000 per annum has now been earmarked as a "health education budget" - mainly for the production and distribution of health films, leaflets and pamphlets, a regular health education magazine, co-ordination of an anti-smoking campaign and so on.

153. One of the department's successes is an annual competition for the cleanest village in Cyprus, with prizes and press publicity, and consequent spin-off in increased public awareness of the importance of environmental hygiene. Private and domestic standards of hygiene are high, but the notion of public responsibility for communal facilities still requires development.

154. Until and unless an adequately-funded health education unit develops to co-ordinate and direct health education efforts, these are likely to continue to operate in a diffused and decentralised manner, as they have to date in independent Cyprus. There has been a tremendous dependence on one-off campaigns; on good personal contacts between individual members of different ministries and departments with each other and with the media; and on the good work of a number of voluntary organistions. One example of co-operation is the excellent health work carried out by the new Cyprus Thalassaemia Centre in conjunction with voluntary associations and with the Ministry of Education, which has now incuded education on thalassaemia in the biology curriculum of primary and secondary schools.

155. Health education, then, reaches the Cypriot public through five main, sometimes co-ordinating, sometimes overlapping, routes. Where the overlap leads to reinforcement of the educational message this has been useful; where it leads to needless duplication it has been wasteful of scarce resources. These five main routes are as follows.

Ministry of health departments and personnel

156. All Ministry of Health personnel who have direct contact with the public see some measure of health education as one of their roles. This is especially true for health inspectors, school health visitors and community health visitors. However, these personnel are already overstretched in their routine tasks (there is one school health visitor for every 3,000 students and each community health visitor covers 10-12 villages) and health education may at times amount to little more than passing on pamphlets, arranging for posters to be pinned up, or telling pregnant women they should be tested for thalassaemia trait. School visitors do, however, arrange for health education talks and films in schools. Individual sections under the Ministry, such as the Thalassaemia Centre, arrange a lot of their own health education, in conjunction with associated voluntary groups. It is hoped that the embryo health education unit will be given the time, financial backing and personnel that it needs to generate and co-ordinate further health education efforts, especially in dealing with the more intractable diseases of civilisation: cardiovascular diseases, cancers and accidents.

Ministry of education and the schools

157. Although primary and secondary schools have no health education curriculum as such, the Ministry of Education is receptive to health education talks being organised in its schools on a wide range of issues. Specialised themes of particular interest to young Cypriots, such as thalassaemia, have now been included in the biology curriculum.

Other government ministries and departments

158. Health education is one small aspect of the work done by some other government departments. The Ministry of Agriculture has home economics aides working with village mothers, who include care and nutrition of children as part of their work. So far there has been little or no health education in factories and other workplaces. The Ministry of Labour employs one occupational health doctor.

Voluntary associations

159. At the present time a great deal of health education rests on the shoulders of a number of highly active, indigenous, voluntary associations. Usually based around a core of disease sufferers, their relatives and friends and those medical personnel responsible for their treatment, these groups have been highly successful in fund-raising activities, gaining media publicity for their cause, organising public talks and sponsored walks, printing leaflets and posters, and generally increasing public awareness. Groups like the entirely voluntary Co-ordinated Committee for Blood Transfusion have actually been able to introduce large-scale blood donation for the first time in Cyprus by organising talks and public events accompanied by follow-up mobile blood collection facilities. They have done this by inciting villages to compete against each other in blood donation, with certificates, prizes and accompanying publicity including the attendance of well-known national figures - and by offering incentives in the form of a guaranteed blood transfusion available for any donor in need. Some 50 per cent of the blood thus collected is earmarked for the routine treatment of thalassaemia patients; the rest is available for general use.

160. Coming as they do from the people, these voluntary associations have shown considerable success in organising the people towards fulfilling the associations' goals. Many have also been astute in gaining key public figures as their presidents or patrons. The patron of the PanCyprian Anti-Anaemia

(Thalassaemia) Association, for example, is the wife of the President of the Republic. The spin-off in education of the public regarding the causes and effects of various diseases is well appreciated, and the relevant health sections and personnel usually work closely with and through the voluntary associations as part of their own health education role.

The media

161. Cyprus is fortunate in having a high literacy rate and general socio-economic development. An estimated 90 per cent plus of families own a radio, 70 per cent a television set, and 70 per cent read a newspaper daily. In the early 1970s a substantial campaign about thalassaemia was backed up by TV and radio advertising and talks. The Thalassaemia Centre has mixed feelings regarding the (partially evaluated) success of the campaign and tends to regard such media exercises as simply back-up and reinforcement for the more important face-to-face communication with groups and individuals.

162. There are a considerable number of daily, weekly and monthly newspapers and magazines in Cyprus, independently owned and across the full political spectrum. These also allocate space to topical health and health education issues, again on a irregular basis. The voluntary associations, in particular, have been able to make considerable use of the medium of the press for publicising health issues, often through good personal or party political contacts. The press has played an important part in publicising and spurring on competition between villages in the areas of environmental hygiene and blood donation.

163. With a few such exceptions, and in spite of a literate population and good media coverage, there has as yet been little systematic or innovative use of the media in health education.

The special case of thalassaemia

164. Thalassaemia, or Cooleys anaemia, is one of the commonest genetic recessive conditions in the Mediterranean and the Middle and Far East. Heterozygote "carriers" are unaffected. Homozygote sufferers with beta thalassaemia major fail to thrive in infancy, develop abnormalities associated with severe anemia, and if untreated will usually die between the ages of one to six years. Up-to-date methods of treatment involve high blood transfusion rates, splenectomy, and regular infusion of an expensive drug to remove excess iron. When two carriers reproduce there is a one in four chance that their offspring will have thalassaemia major. One in seven Cypriots carries the recessive gene for thalassaemia. Cyprus currently has some 600 or so homozygote thalassaemia patients. In 1981 patients treated required 9,367 units of blood at a cost of some £65,569 and 255,500 vials of desferal representing in monetary terms 17.7 per cent of the drug budget of the Ministry of Health and 2.75 per cent of its overall budget for the year.

165. In view of the cost and of the human misery engendered by thalassaemia, current emphasis is on prevention. To date, though medical research holds hope for the future, this can only be achieved by dissuading thalassaemia trait carriers from marrying each other and reproducing, or by the abortion of affected foetuses.

166. Thalassaemia provides an interesting case of how the direction of education and guidance given to the public has shifted in response first to newly available medical techniques, and second to the willingness of the public to change traditional patterns of behaviour. Before the availability of ante-natal diagnosis, the emphasis in education, screening and genetic counselling was on young girls

approaching marriageable age, with the aim of preventing, voluntarily, marriage between heterozygotes. Not surprisingly, may resented the intrusive nature of this knowledge and its effect on their choice of partner, feeling that their social life and traditional marriage patterns were being threatened. Response to a campaign of public information was therefore very mixed, some pressing for legislation to screen the population and prevent marriage between carriers, others wishing away the information as an intrusion on their personal liberty.

167. By 1977, ante-natal diagnosis of affected foetuses was available abroad, and the Government provided financial aid to those willing to take advantage of it. In 1981 the test became available in Cyprus itself. The emphasis of the public information campaign changed towards one of preventing homozygote births. Offered the ability to take responsible decisions regarding their families, without interference with marriage choices and patterns, Cypriots responded quickly. Not only at-risk married couples came forward for testing but, increasingly, young engaged couples and unmarried individuals. In 1981 out of a potential 80 thalassaemia major births only 3 homozygotes were in fact born. Control of thalassaemia by prevention of homozygote births has nearly been realised in Cyprus.

Notes

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LESSONS LEARNED

168. What are the main lessons learned from these case studies in community health education?

169. First, the three countries addressed different problems. In Tanzania and Sri Lanka these were basic primary health care issues of environmental and personal hygiene. In Sri Lanka they also included immunisation and family planning. Cyprus, on the other hand, faced the problem of thalassaemia, one in seven Cypriots carrying the recessive gene, with possible serious consequences for future offspring. In all three countries, the focus was on whole communities, not special target groups. Community health education thus reflected specific concerns in the countries.

170. Second, the strategies were quite different. Tanzania, with its formerly dispersed population grouped into villages, tried to reach a large number of people through radio. Sri Lanka has taken advantage of its well-educated young people in the villages, to make them the link between primary health care services and the community. And Cyprus responded quickly to available technology as it has become possible to do something about thalassaemia through ante-natal testing.

171. Probably the country which has had most success in reaching its aims is Cyprus, but it seems that the technological breakthrough of ante-natal diagnosis made all the difference to community acceptance: the community was only partially responsive to genetic counselling, screening, and education campaigns until the new medical techniques were introduced. The extent to which behaviour

changed in relation to latrine usage, for example, in Tanzania is difficult to assess, although levels of knowledge have certainly improved. In Sri Lanka some of the villages claim to have avoided cholera outbreaks since they have introduced volunteers to encourage villagers to boil drinking water and use latrines.

172. What is notable is that each country has seen community health education differently, and has involved communities in action in different ways. The case studies thus present community health education as an adaptable and flexible concept.

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-mil 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 Karella 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 systematicaly 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 hierarchichal 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.

205. Many health educators are attracted to the idea of using television and radio for health education. Aside from being glamorous and "modern", these media have the potential of reaching very large numbers of people. In the less developed countries these factors may be particularly influential, reinforced by the enthusiasm of foreign aid donors to give and countries to sell equipment.

206. However, heavy emphasis on electronic media has lately been heavily criticised. Experience in the Western industrialised world and a few Third world countries suggests that using mass media to change people's health behaviour is often disappointing. The reasons for this are extremely complex. Some claim that inappropriate comparisons have been made with commercial advertising (Tones, 1981). Others maintain that preventive medicine and health education have a relatively low status and that their messages are therefore more likely to be accepted if presented by a high-status physician in an individual interview rather than over radio or television (Bunnag, 1981). Most communication theorists argue that the opportunity for dialogue is the sine qua non of effective communication, and that mass media do not usually allow for this. The theoretical debate on the effects of the media on people's behaviour is complex however (Flay, 1981) and not considered here. What is increasingly accepted is that if the mass media have any influence on their own it tends to be in the direction of reinforcing existing beliefs and opinions, rather than in changing or converting them (McCron and Budd, 1979).

Which mass media?

207. In talking of mass media in developing countries, the emphasis is usually on radio. Other media - television, newspapers, journals and magazines, tape cassettes, slide sets, films, even billboards or people's newspapers or wall papers - are usually more limited. In fact, in a recent Commonwealth report it was stated that radio is "the medium of the people, reaching as it does across the barrier of literacy and limited in its potential penetration only by the availability of transmission equipment and of radio receivers" (Commonwealth Committee on Communication and the Media, 1980). Newspaper circulation, on the other hand, has tended to diminish over the last decade and television is still fairly limited in less developed Commonwealth countries.

208. From the response to questionnaires it appears that most Commonwealth countries regard radio as a potentially useful method for health education, although few countries have actually realised this potential. There are some important difficulties to using mass media techniques. Thus the benefits of reaching wide audiences have to be balanced against two basic problems: first the technical constraints, and second the communication process itself.

Technical constraints

209. Starting from the premise that radio carries the most promise for mass communication, we concentrate on it here. However, many of the points made are relevant for other media.

210. There are a number of obvious technological difficulties that limit coverage by radio. Underdeveloped infrastructures may mean that transmission and reception are imperfect. The production of radios and distribution networks may not be equal to meeting demand for radios or batteries. Multilingual countries cannot always satisfy all sectors of the population and often the majority of programmes are in the national (urban) language which is not common to all. Financial constraints exist in many countries which still import radios or some of the materials to make them.

The communication process

211. In terms of communication there are other problems. One major constraint of radio is the impermanence of the message. If the recipient cannot keep pace with what is being broadcast, the message is lost. The radio broadcaster cannot even know if it has been received, let alone understood. The process of communicating - from communicator to message to recipient - is compiex, and most health educators argue that one-to-one, face-to-face communication is the nearest a communicator can come to being certain that the message is understood and accepted. It is an interactive relationship. Even then there are many pitfalls: recipients may pretend to understand; may think that they understand; may understand but not agree; may understand and agree, but not always change their behaviour.

212. How much more difficult, then, to ensure that in mass communication messages are understood and well-received, let alone acted upon. Furthermore, radio (or television) is not received in isolation; it is beamed into a social setting - a family house, a bar or cafe, a school or a public square. In all these situations there are individuals with existing beliefs and values and to whom friends, workmates, teachers are still important founts of information who may influence attitudes and behaviour. People are not passive recipients in the communication process. Nor do people have equal access to media. Low status may exclude certain groups like women and children from listening to what is a highly-prized consumer item. As McCron says, there is no reason to suppose that the mass media are a particularly effective communication source. The messages received "may reinforce those obtained from primary health groups, but they may equally contradict them. Primary group contacts serve to mediate or filter mass-communicated messages" (McCron and Budd, 1981). In other words, people are active participants in a communication exchange which selects and interprets from the message in line with their existing knowledge and predispositions.

213. It thus becomes clear that messages produced nationally in urban centres may be, however factual or right minded, unacceptable or of little consequence to rural people. One of the points made in the Commonwealth report on the media is that the colonial experience has left many countries with heavily urban-biased media, and that even where the desire is to extend broadcasts to rural areas, professionals are hampered by their own attitudes and orientations. From his experience in Africa, Fuglesang reminds professionals of the rich oral traditions of many societies: "We judge people on how they express themselves in a secondary language like English or French, and we do not realise that village people, and particularly the elders, usually are highly vocal, witty and sophisticated in their speech. Parents take pride in teaching their children to speak the tribal language properly ... Radio could be so obviously the most powerful medium in any local society, if only the tribal languages in the programmes and the quality of the narrators were better" (Fuglesang, 1981).

How effective are mass media?

214. In spite of its constraints then, radio remains enormously attractive because of its relative efficiency and cheapness in reaching large audiences. Many health

educators believe in it, and indeed use it in a number of ways - for short health education talks, doctors' forums, quizzes, sometimes drama with a health message. However, there has been little evaluation of its effectiveness. One review of health and nutrition projects using mass media techniques concluded that there is almost no evidence concerning the impact of mass media health and nutrition education projects on the health status of the target audience (Leslie, 1981). In this review six health education projects - in Guatemala, Haiti, India, Kenya, Tanzania and Senegal - were assessed. Three used radio only (one included supporting literature), two used television, and one used audio-cassettes.

215. In Kenya, the target audience was rural adults and the project was a series of comedy programmes on radio into which were dispersed health messages. Extremely popular, the weekly programmes reach up to three million people and are ongoing. How much they influence people's health behaviour has not been tested.

216. The Tanzanian radio campaign has been considered earlier in this report; here there was an attempt to evaluate effectiveness. One measure used was the number of latrines built as a result of the campaign (750,000). However, it was not possible to say whether constructing latrines had improved people's health. The television programme in Senegal (see paragraph 193) was aimed at illiterate working class women, and took the form of twice-weekly television films shown in clubs on such subjects as the cause and treatment of malaria, dysentry and tuberculosis, and the promotion of less oil for cooking; certain educational goals were achieved (more women knew that the mosquito caused malaria) and women claimed to use less oil in cooking.

217. Haiti has had an annual twelve-week radio campaign for school children and their teachers on immunisation and population growth; Guatemala a three-week campaign using cassettes at community laundering places to promote vaccinations and food supplements; and in India a one-year project using television for rural adults gave information on preventive measures. Some evaluation of the projects took place in India (gains in knowledge) and Guatemala (more children were vaccinated than in areas without cassettes), but the results are disappointing. Most of the projects were not ongoing.

218. Leslie also reviews nine nutrition education projects, most of which were able to show some positive gain in achieving educational objectives. For example, after a six-week radio, television and newspaper campaign in Trinidad and Tobago to persuade mothers and pregnant women that breast-feeding is preferable to bottle feeding, it was found that more mothers were aware of the issue, and also that many introduced bottle feeding at a later age than they would otherwise have done.

219. The review of these projects demonstrates how difficult it is to evaluate the effectiveness of health education projects. Few measures get beyond counting the number of radio transmissions made or the number of people contacted; few try to test before and after the project to measure changes in attitudes or knowledge; but measuring a change in morbidity or mortality or even anthropometric change directly due to a health education campaign is methodologically difficult. Leslie concludes that by making appropriate changes in evaluation methodology it is possible to measure the cost-effectiveness of using the mass media for health and nutrition education, but the extent to which other measures of effectiveness can be used is at present uncertain.

220. In another useful assessment of health education projects and the media (Jenkins, 1982) certain conclusions are drawn which provide guidelines to the most effective use of media for health education. The evidence from reviewing a number of successful projects leads Jenkins to conclude that media in health education will have most impact where media projects are integrated with health

services. An educational effort divorced from such support is relatively ineffective. Furthermore, using media alone to project health messages is very unlikely to lead to a change in behaviour. Media can more effectively be used to produce an atmosphere in which changes can take place, or to provide reinforcement once change has occurred.

221. In gathering together her evidence, Jenkins says that, of media used, radio emerges as the most useful, reaching as it does large audiences including illiterate people, provided that broadcasts are made in appropriate languages. Television remains a realistic medium for very few developing countries. It is far more expensive than radio, and there is little difference in the effects or functions of the two broadcast media. "The one difference is that television acts like a magnet: once it is there people watch it." Cassettes have the advantage that they can be replayed, the technology is relatively simple, and where equipment is available they can be used to enable community participation in production. Finally, Jenkins comes down firmly on the side of printed materials: "Although radio comes across ... as the dominant medium .., print is by far the most important and extensively-used medium of instruction; it is less glamorous than broadcasts and its use is consistently under-reported". This is perhaps a more controversial point: in many illiterate societies the importance of story-telling may outweigh the value of visual material, whether in pictures or words. In Fuglesang's words, "It is nonsense to ask 'which medium is best? The important thing is the message design, the development of a 'people's language' which can be used in any available medium" (Fuglesang, 1981).

Conclusions

222. In reviewing the range of literature and experience on health education using mass media, two essential conclusions should guide health educators and policy makers.

223. First, radio as a general educational tool works better when complemented by printed materials and different processes of interpersonal communication, and when used for health-oriented education it should be integrated with the health services.

224. Second, while mass media **may** be useful tool in some aspects of the health educator's work, this must be carefully thought out. Unless health educators and their collabrating broadcasters have a clear image of what they are trying to do and why (which requires an understanding of the people they are trying to reach and the nature of the communication influence), any use of the mass media is likely to end in frustration.

Notes

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CONCLUSIONS

225. This study is witness to the increasing legitimacy given by governments to health education. Almost all the countries in the Commonwealth have a health education section in, or attached to, the ministry of health. It is clear too that health education extends further than the ministry of health, to many other government sectors, and to non-governmental organisations. For all that, health education does not have high status, as reflected by the resources available for it and the numbers of professionals involved in it.

226. In the same way, community health education is accorded a place of some importance by health education units, but few are doing much **with** the community. For example, high priority is given to the production of materials which are usually used in classic situations: classrooms, outpatient clinics, or to specific target groups, with little community involvement.

227. This may in part be due to an underlying tension for many of those involved in health education. Promoting community health education may threaten institutional interests (local government, local landlords, industry and so on), and health educators may find themselves in difficult positions unless their own objectives are clearly worked out. There are also conflicts in relation to professional status: one school of health educators argues for greater professionalisation - for a group of specialists who are the co-ordinators, promoters and catalysts of health education activities. The other school sees health education as an integral part of all activities related to health, which should involve all health workers and also groups like teachers. In reality, most countries fall somewhere along the continuum between those two positions, having health education specialists at national and sometimes regional level part of whose job is to orientate other professionals towards health education.

228. Certain conclusions about community health education do emerge from our review of the literature and countries' responses.

229. First, community health education demands a decentralised approach, local control, and a great deal of consultation with local communities to determine **their** wants. The motivation of the community is all-important.

230. Second, community health education activities must be integrated with local health (and other) services, to ensure continuity. Involving primary health care workers is essential. One of the useful ways of doing this is through district or regional training seminars or workshops.

231. Third, health education units could look more widely at community activities outside government to see what is being done in the health education field.

232. Fourth, community health education activities must be carried out in the broad context of promotion as well as other community activities. This probably means campaigning at national level (to prohibit advertising of tobacco, prohibit smoking in public places, promote compulsory use of seat belts, encourage use of local foods, etc.).

233. Fifth, much more work could be done in evaluation and assessment of activities of health education units, both of particular projects and of priorities within the unit's programme of activities over time.

234. Sixth, more imagination could be used in bringing together different professionals for community health education activities. A multi-disciplinary approach can be a way of releasing extra energy.

235. Seventh, although mass media have their place, too much reliance on technology is not effective. Radio, in particular, has great potential, but allowances must be made for feedback through such mechanisms as listening groups. "Spots" are not good enough; there needs to be follow-up of the information relayed. Local language and life styles must be taken account of in the design of programmes.

236. Finally, much more could be done regionally, with more sharing of training facilities and exchange of ideas and experience. Workshops and seminars on resources, methods, strategies, and techniques in community health education could be a mutually stimulating way for Commonwealth countries in a particular region to expand their community health education activities.

RECOMMENDATIONS

237. From the analysis of countries' responses to the questionnaire and the survey of community health education we make the following recomendations for action.

National

238. Recognition should be given to the importance of community health education by establishing permanent planning arrangements between sectors, especially ministries of health and education, the media, and universities or other institutions of higher education.

239. At the same time, an attempt should be made to decentralise community health education activities, giving local communities as much say in decision-making about community health as possible.

240. The status of health education should be raised by improving resource inputs not only financially but also in terms of professional training for those involved in health education.

241. Serious consideration should be given to promotive action at national level in consultation with the tobacco, food and transport industries, for instance - to both improve community health and avoid the entrenchment of patterns of life that are known to contribute to a high risk of morbidity or mortality.

242. In view of the potentially deleterious effects on health of alcohol and tobacco, government policies regarding revenue from tobacco and alcohol (in particular) and their advertising and promotion through the mass media should be reviewed.

Regional

243. In order to stimulate interest and pool resources between Commonwealth countries, regional groups should discuss co-operation in community health education, using the medium of regional workshops for an initial exchange of ideas.

244. Regional universities and other educational institutions should publicise and exchange information on health education training courses to countries within the region, to establish more appropriate and effective collaboration in training for health education.

245. Regional workshops should be held on a regular basis to identify the scope of activities in national health information/education/promotion programmes with special reference to trends in communication through the mass media.

Commonwealth Secretariat

246. The Commonwealth Secretariat should, where possible, encourage discussion and exchange of information on community health education by:

(a) supporting regional workshops for those involved in community health education, both for professional health educators and for others working in education, media and relevant areas;

(b) providing technical assistance for such workshops where requested;

(c) providing scholarships or other financial assistance to individuals for further training where governments feel this appropriate.

247. The Commonwealth Secretariat should encourage governments to consider what promotive action can be taken on a national scale regarding tobacco and alcohol, food and transport, in order to improve community health.

COUNTRY PROFILES

AUSTRALIA

Each state has its own health education unit.

High priority activities: differ from state to state; include production of materials, training courses, radio and television programmes and newspaper and journal information.

Involvement of community voluntary organisations: considerable use of voluntary groups, e.g. National Heart Foundation; Cancer Society; Family Planning Association; and many others.

Innovatory projects: for example, breakfast programmes in schools, "healthy state" shops, health assessment packages.

Health education in schools: primary and secondary; specially designed media schools programmes.

Institutions providing health education qualifications: Canberra College of Advanced Education, W.A.I.T. Division of Health Sciences, W.A.C.A.E. Claremont Campus, Sturt College of Advanced Education, Burwood College of Advanced Education, Toorak College of Advanced Education, Sydney College of Advanced Education, Wollongong Institute of Education, Kelvin Grove College of Advanced Education. Also Masters in Public Health with health education proponent at University of Sydney.

BAHAMAS

Health education division

High priority activities: production of materials; training courses; radio and TV programmes.

Community involvement voluntary organisations: Kiwanis Club involved in immunisation campaign; Service clubs; Cancer Society.

Innovatory projects: training members of voluntary and civic organisations to take part in community health education.

Health education in schools: none.

Institutions abroad used for health education qualifications: Amherst University, Boston, Mass., USA.

BARBADOS

No health education unit. Health education officer.

High priority activities: production of materials; radio and TV programmes; newspaper and journal information; outpatient clinic programmes. **Also,** dental health, blood donorship, drug abuse, anti-litter.

Community involvement/voluntary organisations: volunteers through a variety of associations and societies, churches, workers' unions. Voluntary organisations included: Family Planning Association; Cancer Society; Diabetic Society; Red Cross; St John's Ambulance.

Health education in schools: primary and secondary; special media programmes for schools.

BELIZE

No health education unit. Health education through public health inspectorate and Peace Corps volunteer.

High priority activities: radio talks, schools programmes.

Health education in schools: secondary; specially designed media programmes for schools.

BOTSWANA

Health education unit.

High priority activities: training courses, outpatient clinics, rural community programmes, peri-urban community programmes. **Also** mobilisation of traditional healers, curriculum development for schools.

Community involvement/voluntary organisations: village health committees, popular theatre, producing radio programmes, Red Cross, women's organisations.

Innovatory projects: workshops to increase community participation and awareness.

Health education in schools: primary and secondary; special media programmes for schools.

Institutions providing health education qualifications: Botswana National Health Institute, P O Box 985, Gaborone.

Institutions abroad used for further qualifications: University of California, University of Michigan, USA; University of Ibadan, Nigeria.

BRITAIN

Health education council.

High priority activities: production of materials, training courses, radio and television programmes, newspaper and journal information.

Community involvement/voluntary organisations: volunteer tutors in exercise classes. "Look after yourself". National Council of Voluntary Organisations; health action groups; Coventry Community Education Development Centre.

Health education in schools: primary and secondary; media programmes for schools.

Institutions providing health education qualifications: Diploma courses at the Polytechnics of Leeds, South Bank (London), Bristol, and the Institute of Education (London). Masters degrees from the University of Manchester and Chelsea College (London). Part-time health education certificates in over 30 colleges. Details from The Health Education Council, 78 New Oxford Street, London WC1A 1AH.

CANADA

Health promotion directorate.

High priority activities: production of materials, training courses, radio and TV programmes. Also non-smoking campaigns, poison prevention, promotion of breast feeding.

Community involvement/voluntary organisations: community-based media involvement. Voluntary organisations include Heart Foundation; Cancer Society; Lung Association and many others.

Health education in schools: primary and secondary; special media schools programmes.

Institutions providing health education qualifications: University of Waterloo, University of Toronto, University of Dalhousie.

Institutions abroad used for further health education qualifications: Various USA universities.

CYPRUS

No health education unit (nucleus has been established).

High priority activities: production of materials, rural and peri-urban community programmes. Also cleanliness campaign, anti-smoking campaigns.

Community involvement/voluntary organisations: voluntary groups, e.g. Co-ordinated Committee for Blood Transfusion; Anti-Anaemia (Thalassaemia) Association; Anti-Cancer Society; Family Planning Association.

Health education in schools: primary and secondary; special media programmes for schools.

Institutions abroad used for health education qualification: proposals to send one person to the University of Beirut, Lebanon, and one person to the University of Leeds, Britain.

DOMINICA

No health education unit (is being established).

High priority activities: preparation of materials, training courses, radio programmes, outpatient clinics, rural and peri-urban community programmes. Also school health education.

Community involvement/voluntary organisations: local discussion and volunteer skills used. Village health committees; adult education committees.

Innovatory projects: monthly themes using media .

Health education in schools: primary and secondary. Syllabus in preparation. Special media programmes for schools.

FIJI

Health education unit.

High priority activities: production of materials, training courses, radio programmes, outpatient clinic programmes, rural and peri-urban community programmes. Also school broadcasts.

Community involvement/voluntary organisations: village health committees, women's groups, Responsible Parenthood Council, Red Cross, St John's Ambulance, YWCA and YMCA.

Health education in schools: primary and secondary; special media programmes for schools.

Institutions abroad used for further health education qualifications: University of Hawaii.

THE GAMBIA

Health education unit.

High priority activities: production of materials, radio programmes, outpatient clinic programmes, rural community programmes.

Community involvement/voluntary organisations: traditional story-tellers and radio artists. Family Planning Association; Catholic Relief Services.

Innovatory projects: mass media projects on oral rehydration and diarrhoea control.

Health education in schools: primary; special media programmes for schools.

Institutions abroad used for further health education qualifications: University of Ibadan, Nigeria.

GHANA

Health education division.

High priority activities: training courses, outpatient clinics, rural and peri-urban community programmes.

Community involvement/voluntary organisations: planning programmes for World Health Day. Red Cross; various Christian churches; village health committees; local councils.

Health education in schools: primary and secondary.

Institutions abroad used for further health education qualifications: University of Ibadan, Nigeria.

GRENADA

Health education department.

High priority activities: production of materials, training courses, radio programmes, rural and peri-urban community programmes. **Also** clean-up campaigns.

Community involvement/voluntary organisations: volunteers in teenage programmes to reduce adolescent pregnancy. St John's Ambulance; National Women's Organisation; National Youth Organisation; Planned Parenthood Association.

Innovatory projects: training community leaders as health educators.

Health education in schools: primary and secondary.

Institutions abroad used for further health education qualifications: University of Michigan, USA.

GUYANA

Division of health education.

High priority activities: production of materials, training courses, radio programmes, outpatient clinic programmes.

Community involvement/voluntary organisations: teachers and school children in school food vendor programme. Responsible Parenthood Association.

Innovatory projects: schools sanitation project.

Health education in schools: pilot project started for primary; special schools media programmes.

Institutions abroad used for further health education qualifications: University of the West Indies, Jamaica; University of Michigan, USA; University of New South Wales, Australia.

INDIA

Central health education bureau.

High priority activities: production of materials, training courses, radio, TV programmes, outpatient clinics. **Also** exhibitions.

Community involvement/voluntary organisations: community often involved in planning and implementation through village councils, youth clubs, women's organisations. Voluntary Health Association; Family Planning Association; Hind Kusht Nivaran Sangh; National Society for the Prevention of Blindness.

Health education in schools: primary and secondary; special media programmes for schools.

Institutions providing health education qualifications: All-India Institute of Hygiene and Public Health, 110 Chittaranjan Avenue, Calcutta; Gandhigram Institute of

Rural Health and Family Planning, PO Ambathurai RS, Maduvai District, Tamil Nadu-624309; Central Health Education Bureau, Kotla Road, New Delhi.

Institutions abroad used for further health education qualifications: Various, but especially Britain and the USA.

JAMAICA

Bureau of health education.

High priority activities: production of materials, rural and peri-urban community programmes. Also displays.

Community involvement/voluntary organisation: teenage volunteers for family life education. Parent and teachers associations, women's groups, church groups, youth groups. Anti-TB League; Health Education League; Kiwanis Lions Club.

Innovatory projects: poultry-rearing to improve nutrition of children.

Health education in schools: primary and secondary; special media schools programmes.

Institutions providing health education qualifications: University of the West Indies, Mona, Kingston 7, Jamaica.

Institutions abroad used for further health education, qualifications: University of Michigan, University of Minnesota, University of Hawaii, USA.

KENYA

Health education unit.

High priority activities: production of materials, radio programmes, rural and peri-urban activities. Also school health education.

Community involvement/voluntary organisations: community leaders sought out. Village health committees; trades unions; National women's organisation.

Health education in schools: primary and secondary; special media programmes for schools.

Institutions providing health education qualifications: Medical Training Centre, PO Box 30195, Nairobi.

Institutions abroad used for further health education qualifications: California State University, University of Chicago, USA; University of Ibadan, Nigeria.

KIRIBATI

Health education unit.

High priority activities: production of materials, training courses, radio programmes, outpatient clinic programmes.

Community involvement/voluntary organisations: village health committees, women's groups, youth and church groups, political parties.

Health education in schools: primary and secondary; special media programmes for schools.

LESOTHO

Health education unit.

High priority activities: production of materials, training courses, radio programmes, hospital programmes, rural and peri-urban community programmes.

Community involvement/voluntary organisations: through village health workers, women's and youth groups, some traditional healers. Red Cross; Planned Parenthood Association.

Innovatory projects: traditional healers, training teachers in school sanitation; training urban outreach workers.

Health education in schools: primary; media programmes for schools.

Institutions abroad used for further health education qualifications: Leeds Polytechnic, Queen Elizabeth College, Britain; Pan African Institute of Development, Zambia.

MALAWI

Health education section.

High priority activities: production of materials, training courses, radio programmes, newspaper and journal information, rural community programmes. Also immunisation weeks, fairs and shows.

Community involvement/voluntary organisations: Red Cross Volunteers; through primary health workers; village health committees.

Innovatory projects: plans to decentralise the regions.

Health education in schools: primary; media programmes for schools.

Institutions abroad used for further health education qualifications: University of Zimbabwe; University of Ibadan, Nigeria.

MALAYSIA

Health education unit.

High priority activities: production of materials, training courses, rural community programmes.

Community involvement: through village health and village development committees.

Health education in schools: primary and secondary; media programmes for schools.

Institutions providing health education qualifications: Public Health Institute, Jalan Bangsar, Kuala Lumpur.

Institutions abroad used for further health education qualifications: University of Michigan, University of California, Berkeley, University of Hawaii, San Diego State University, Tulane University, USA.

MALTA

Health education unit.

High priority activities: production of materials, radio programmes, newspaper and journal information, outpatient clinic programmes. **Also** anti-smoking, diabetes and breast-feeding campaigns.

Community involvement/voluntary organisations: voluntary groups carry out drug abuse and diabetes education and marriage counselling. Family Planning Association.

Health education in schools: primary and secondary; media programmes for schools.

MAURITIUS

Health education unit.

High priority activities: production of materials, training courses, radio and TV programmes, outpatient clinics.

Community involvement/voluntary organisations: Sugar Industry Labour Welfare Centre involved in rural development project. Red Cross gives health training. Various workers' unions, women's associations, village councils, etc.

Health education in schools: primary and secondary; media programmes for schools.

Institutions abroad used for further health education qualifications: Ecole Nationale de la Sante Publique, Rennes, France.

NAURU

No health education unit. Community health department, general hospital.

High priority activities: special campaign run during outbreak of communicable diseases.

Health education in schools: none.

NEW ZEALAND

Health education and information unit.

High priority activities: production of materials. Also health advertising.

Community involvement/voluntary organisations: Cancer Society; National Heart Foundation.

Health education in schools: primary; media programmes for schools.

Institutions abroad used for further health education qualifications: WHO Regional Teacher Training for Health Personnel, New South Wales, Australia.

NIGERIA

Federal health education division.

High priority activities: production of materials, training courses, radio programmes, newspaper and journal information, hospital and outpatient clinic programmes, rural and peri-urban community programmes.

Community involvement/voluntary organisations: voluntary committees. Red Cross; missionary churches; National Council of Women's Societies; family planning.

Health education in schools: primary and secondary; media programmes for schools.

Institutions providing health education qualifications: University of Ibadan, Nigeria.

Institutions abroad used for further health education qualifications: University of Michigan, University of Illinois and other North American universities.

PAPUA NEW GUINEA

Health education section.

High priority activities: production of materials, training courses, radio programmes, rural and peri-urban commuity programmes.

Community involvement/voluntary organisations: individual volunteers, village health committees, women's groups. Family Planning Association; Life-line; various Christian groups.

Health education in schools: primary and secondary; media programmes for schools.

Institutions providing health education qualifications: Institute of Health Education.

Institutions abroad used for further health education qualifications: Lomacind University, Cornell University, USA; University of New South Wales, Australia; Macquarie University, Australia.

ST LUCIA

Bureau of health education.

High priority activities: production of materials, training courses, radio programmes, outpatient programmes, rural and peri-urban community programmes.

Community involvement/voluntary organisations: health committees, parent and teacher associations. Family Planning Associations.

Health education in schools: primary and secondary; media programmes for schools.

Institutions abroad used for further health education qualifications: University of West Indies, Jamaica.

ST KITTS-NEVIS

Health education unit.

High priority activities: production of materials, training courses, radio programmes, rural and peri-urban community programmes.

Community involvement/voluntary organisations: communities involved in production of materials for health campaigns; women's groups; health committees; church.

Health education in schools: primary and secondary.

ST VINCENT AND THE GRENADINES

Health education unit.

High priority activities: production of materials, training programmes, radio programmes, outpatient clinic programmes, rural community programmes. Also family life education for adolescents.

Community involvement/voluntary organisations: adolescents as peer counsellors, other volunteers. Planned Parenthood Association; Service clubs; Jaycees.

Innovatory projects: training adolescents in peer counselling.

Health education in schools: primary.

Institutions abroad used for further health education qualifications: University of the West Indies, Jamaica.

SEYCHELLES

Health education and nutrition unit.

High priority activities: production of materials, training courses, radio programmes, newspaper and journals, rural and peri-urban programmes, theatre or drama programmes. Also teenage pregnancies, sexually transmitted diseases projects.

Community involvement/voluntary organisations: in all activities. Voluntary organisations include: Catholic Relief Services; women's association; nurses' association.

Health education in schools: primary and secondary; media programmes for schools.

SIERRA LEONE

Health education division.

High priority activities: production of materials, training courses, radio programmes, outpatient clinics.

Community involvement/voluntary organisations: volunteers in primary health care, village health committees, religious associations, women's organisations. Planned Parenthood Association.

Health eduction in schools: primary and secondary; media programmes for schools.

Institutions providing health education qualifications: University of Sierra Leone.

Institutions abroad used for further health education qualifications: University of Ibadan, Nigeria; Tuskege University, USA.

SINGAPORE

Training and health education department.

High priority activities: production of materials, radio programmes, newspaper and journal information, peri-urban community programmes. **Also** family life and population for factory workers.

Community involvement/voluntary organisations: volunteers give family planning talks in Malay language. Youth groups, women's groups, religious associations, trade unions, Family Planning Association, National Heart Association, Cancer Society.

Innovatory projects: scripts and slides on health topics for schools; health articles to in-house newsletters.

Health education in schools: primary; media programmes for schools.

SOLOMON ISLANDS

Health education division.

High priority activities: production of materials, training courses, radio programmes, rural community programmes.

Community involvement/voluntary organisations: women's workshops, primary health care workers and village aids and village health committees. Peace Corps volunteers train village leaders in community health.

Health education in schools: primary and secondary.

SRI LANKA

Health education bureau.

High priority activities: production of materials, training programmes, radio programmes, hospital programmes, rural community programmes. **Also** anti-malaria, anti-VD, anti-cancer campaigns.

Community involvement/voluntary organisations: volunteers at family level. Family Planning Association; Sarvodaya; National Association for the Prevention of TB; Cancer Society.

Health education in schools: primary and secondary; media programmes for schools.

Institutions providing health education qualifications: University of Colombo, Kynsey Road, Colombo 8 (proposed course). Health education bureau.

Institutions abroad used for further health education qualifications: Various universities in the USA, India and Manila.

SWAZILAND

Health education centre.

High priority activities: production of materials, training courses, radio programmes, rural community programmes.

Community involvement/voluntary organisations: local volunteers especially in latrine construction and protection of wells. Red Cross; Family Life Association.

Innovatory projects: using theatre as education strategy.

Health education in schools: Primary curriculum being developed.

Institutions abroad used for further health education qualifications: University of Ibadan, Nigeria.

TANZANIA

Health education unit.

High priority activities: production of material, training courses, radio campaigns, peri-urban community programmes.

Community involvement/voluntary organisations: Family Planning Association; Women's organisation.

Health education in schools: primary plans in preparation; media programmes for schools.

Institutions abroad used for further health education qualifications: University of Ibadan, Nigeria; University of North Carolina, USA; University of Beirut, Lebanon.

TONGA

Health education division.

High priority activities: production of materials, radio programmes, newspaper and journal information, rural community programmes. **Also** diarrhoeal diseases campaign.

Community involvement/voluntary organisations: village volunteers selected by village to work on diarrhoeal campaign. Women's groups.

Health education in schools: None.

Institutions abroad used for further health education qualifications: University of Ibadan, Nigeria.

TUVALU

Public health unit.

High priority activities: radio programmes, rural community programmes.

Community involvement/voluntary organisations: women's committees and island councils. Family Planning Association.

Health education in schools: None.

Institutions abroad used for further health education qualifications: University of Papua New Guinea.

UGANDA

Health education division.

High priority activities: production of materials, training courses, peri-urban community programmes.

Community involvement/voluntary organisations: in community development programmes and village health committees.

Health education in schools: primary and secondary; media programmes for schools.

Institutions abroad used for further health education qualifications: University of Ibadan, Nigeria; University of North Carolina, USA.

VANUATU

Health education section.

High priority activities: production of materials, training courses, radio programmes, peri-urban community programmes.

Community involvement/voluntary organisations: through women's groups, village health committees and youth groups.

Health education in schools: None.

WESTERN SAMOA

Health education office.

High priority activities: production of materials, training programmes, radio programmes, newspaper and journal information, rural and peri-urban community programmes. Also breast-feeding and family planning campaigns.

Community involvement/voluntary organisations: voluntary workers in primary health care, village health committees, women's and youth groups. Red Cross; church groups; Civic Organisation.

Innovatory projects: income-generating activities like vegetable gardening, poultry raising.

Health education in schools: primary and secondary; media programmes for schools.

ZAMBIA

Health education unit.

High priority activities: production of materials, training courses, rural community programmes. **Also** functional literacy.

Community involvement/voluntary organisations: through community health workers, village health committees and adult literacy groups. Red Cross.

Health education in schools: primary and secondary; media programmes for schools.

Institutions abroad used for further health education qualifications: University of Ibadan, Nigeria.

ZIMBABWE

Health education department.

High priority activities: production of materials, training courses, radio and television programmes, outpatient clinic programmes, rural and peri-urban programmes.

Community involvement/voluntary organisations: village chooses primary health care worker. Village health committees; Red Cross; St John's Ambulance; Christian missions.

Health education in schools: primary and secondary; media programmes for schools being developed.

Institutions providing a health education qualification: University of Zimbabwe; Ministry of Health in conjunction with University of Zimbabwe; Domboshawa Technical Training College.

BRUNEI

No health education unit. Public health division.

High priority activities: production of materials, radio programmes, newspaper information, rural community programmes.

Community involvement/voluntary organisations: total community involvement in health week "clean-up" campaign.

Health education in schools: primary.

COOK ISLANDS

No health education unit. Public health division.

High priority activities: rural and peri-urban community programmes.

Community involvement/voluntary organisations: child welfare committee, school teachers, Boys Brigade, Girl Guides, youth groups, village committees.

Health education in schools: primary and secondary.

Institutions abroad used for health eduction qualifications: East West Centre, Hawaii, USA; University of Papua New Guinea.

MONTSERRAT

No health education unit. Health educator.

High priority activities: production of materials, radio programmes, newspaper information, rural community programmes, outpatient clinics.

Community involvement/voluntary organisations: community youth groups involved in hypertension and diabetes programmes; church and community groups.

Health education in schools: primary and secondary.

SELECTED BIBLIOGRAPHY

American Public Health Association, 1982, **Primary health care issues: using radio,** Series 1, No 1, 56 pages.

This is a general introduction to the use of radio in primary health care, both for getting over particular health messages and for keeping in touch with health workers working in isolated areas. The main body of the text presents guidelines for development which may be useful for planners thinking about projects using radio for health education. There are short descriptions of projects in a variety of countries and a bibliography.

Bassey Williams, P, 1980, **The need for a comprehensive health education programme in Nigeria,** Royal Society of Health journal, 100 (3), 90-94.

A very useful and hard-hitting article which criticises the increasing shift away from preventive towards curative medicine which has characterised the Nigerian health services. A system which is top heavy in academic/curative medicine is, states the author, patently not working to the advantage of the Nigerian people when an estimated 44.6 per cent of deaths in the capital city alone are caused by readily preventable diseases. The author proposes guidelines for comprehensive health education of the populace and provides a list of eight suggested priorities for a health education programme which would be relevant discussion points for countries other than Nigeria. Particular emphasis is laid on co-operative programmes, especially co-operation between the Education and Health Ministries.

Byram M, Kuate C B, Matenge K, 1980, **Botswana takes a participatory approach to mass media educational campaign,** Development Communication Report, No 32, October 6-8. Publication of Clearing-House on Development Communication.

This is a useful review of the successes and shortcomings of a radio learning group campaign in Botswana. In this instance the theme was "Understanding Government" but the technique suggests itself strongly for health education in scattered rural settlements.

Crowley D, Etherington A, Kidd R, 1981, (revised edition) **Mass media manual: how to run a radio learning group campaign,** Frederich-Ebert-Sriftung, Germany, 186 pages.

A clear, step-by-step manual, with a useful section on evaluation, based on successful campaigns run in Tanzania and Botswana. Useful short, selected bibliography.

Drummond T, 1975, **Using the method of Paulo Freire in nutrition education: an experimental plan for community action in North East Brazil,** Cornell International Nutrition Monograph Series No 3, 55 pages. Cornell University Programme in International Nutrition and Development Policy.

A nutritionist describes her attempt to translate the teachings of the Brazilian educationalist Paulo Freire into action, gaining the participation of the people of four rural Brazilian villages in a programme of nutrition education aimed at improving the nutritional status of young children. Interesting for those seeking applications of Freire's philosophy in the health field and/or those seeking innovative approaches in the field of nutrition education.

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

A small but thoroughly evaluated study demonstrating that two relatively low-cost innovations, namely short in-service teacher training in health education together with co-ordinated action between school teachers and health personnel, have a significant effect on the health knowledge, attitudes and, most importantly, the practices of rural schoolchildren.

Epskamp C, 1979, **Media education and development: a bibliography**, Centre for the Study of Education in Developing Countries, The Hague, Netherlands, 94 pages.

This is a selected but unannotated bibliography grouped into three sections: mass media; media and development; and media, education and development. The author points out that, in spite of the considerable literature on modern audio-visual media, evaluations of the educational impact of instructional media are rare.

Gatherer A, Parfit J, Porter E, Vessey M, 1979, **Is health education effective?** The Health Education Council, London, 92 pages.

This is an extremely useful compendium of health education studies over the last 10-15 years for which there has been some evaluation. Though reviewing mostly the problems and approaches in the Western world, there are some data from developing countries, especially under the "Community methods" section. Well laid out, the publication has three main sections:

(a) a theoretical discussion of the aims of health education and the purpose and direction of evaluation;

(b) abstracts of some 250 references, grouped according to the method of health education used - data clearly organised;

(c) a general summary of the overall findings with conclusions.

Gramiccia G, 1981, **Health education in malaria control - why has it failed?** World Health Forum 2 (3), 385-393.

The article pinpoints four main reasons for the failure of health education in malaria control:

(a) the type of populations that suffer from endemic malaria - the fact that these are usually rural people in depressed areas means, says the author, that they suffer from isolation, apathy, lack of capacity for understanding and insufficient physical, mental and social resources;

(b) malaria is part of a socioeconomic depression complex from which people have difficulty singling out malaria for particular concern: "the

multiplicity of afflictions from which the people suffer takes away a good part of the motivation they might have for self-help in controlling malaria";

(c) the nature of the disease itself - specifically the complexity of its epidemiology;

(d) the health education methods themselves, which have not been well adapted to local situations.

The author's main recommendation is that education programmes should be developed in detail by an epidemiologist, a sociologist and a health educator, fully acquainted with the local situation and working together.

See also: Brieger W R, 1981, **Health education can help if properly conducted,** a letter to Readers Forum, World Health Forum 2 (4), 578.

Brieger points out that Gramiccia's fourth reason, inappropriately conducted health education in malaria, is the most likely reason for programme failure. Techniques geared to providing knowledge and motivating "apathetic" populations miss the point that "behavioural characteristics that lead to the spread of malaria are rooted in economic and cultural factors, not intellectual ones". Motivation already exists, and it is up to the professional to determine, and to work within, the existing motivations, needs and interests of the community. Also "lack of understanding is not the main reason why people do not accept new kinds of behaviour. It is rather that they are inconvenient, uncomfortable, expensive, produce side-effects, and do not give visible results". He ends up by suggesting that existing malaria technologies need to be improved.

Green L W, 1979, **National policy in the promotion of health,** International Journal of Health Education 22 (3), 161-168.

The author offers a broad definition of health promotion as "any combination of health education and related organisational, economic and political interventions designed to facilitate behavioural and environmental changes conducive to health". He examines the paradoxes which confront governments in policy-making and provides some models in health promotion which help to identify the actors, issues and needs involved in policy. Strong emphasis is put on the need to decentralise decision-making. "Information", says Green, "can be centralised but education cannot." This leads him to a consideration of the role of the mass media, some reasons for its failure as a tool of health education ("problems get defined in some insipid, average way and particular problems of sub-groups, of cultural groups, of geographical regions, get glossed over") and its potential as an untapped source for health education, "not in changing people's behaviour, but more likely in reinforcing and supporting behaviour that is being changed through more decentralised local processes of decision-making and change".

Green L W, Kreuter M W, Deeds S G, Partridge K B, 1980, **Health education planning: a diagnostic approach,** Mayfield, California, 306 pages.

This is essentially practical for health educators, which takes as its definition of health education "any combination of learning experiences designed to facilitate voluntary adaptations of behaviour conducive to health". the authors purpose a model called PRECEDE, "a tool to use intelligently in drawing on and applying the most appropriate scientific theories and educational technologies in planning effective health education". It helps health educators to diagnose the problem, and uses the concepts of predisposing factors, enabling factors and reinforcing

factors to plan health education programmes. It is a book many will find useful. It goes through the model in simple stages, with exercises and examples. There are diagrams to clarify the concepts. While it is particularly orientated to North America, there is no reason why the basic model should not be used elsewhere.

Health Education Council, **10th International Conference in Health Education,** London, 2-7 September 1979. Published by the Health Education Council, England, and the Scottish Health Education Group, 1980, 167 pages plus appendices.

The conference was entitled "Health education in action: achievements and priorities" and was attended by delegates from 76 countries (including many Commonwealth countries). The conference was organised around three main themes:

(a) Public policy: what progress had member countries of the International Union for Health Education made in the integration of health education in national planning?

(b) Youth: what developments had taken place related to health education in youth, especially in the areas of preparation for parenthood, the pre-school child, primary education and adolescence and young adulthood?

(c) Methodology: what methods have health educators developed to assess needs and priorities, to define objectives, to carry out programme evaluations and to develop educational strategies?

The report contains the main addresses to the conference and the keynote papers on each main theme and sub-theme, plus an evaluation of the conference and a list of the names and addresses of all conference delegates.

See also: **Abstracts: 10th International Conference on Health Education,** London, 1979, 61 pages.

Issued as a separate publication from the conference report, this contains an abstract of all the papers presented at the conference plus alphabetical lists of authors, countries and subjects.

Hellberg H, 1980, **Government attitudes to health education: a crucial factor in effective action,** International Journal of Health Education, 23 (2) 76-81.

The author argues cogently that it is a government's responsibility to provide an administrative and legislative framework supportive of community action, through individuals and groups in the area of health education. Governments should also recognise and facilitate the role of voluntary agencies, share information about health and the health consequences of certain practices and behaviour with the entire population and accept financial responsibility in developing a policy for health promotion.

Ho H S, and Chee Eng Nam A, 1980, **Factors influencing the outcome of health campaigns: a case study in Singapore,** International Journal of Health Education, 23 (4), 247-252.

This describes a follow-up on a national health campaign against infectious diseases using a combination of exhibitions, film shows, schools competitions, newspaper, radio and TV, in a country with four official languages and many

spoken dialects. Of those aware of the campaign (52 per cent), increased awareness of the facts of diseases were greatest among the younger, better educated, and economically better-off. In other words, although the authors do not spell it out, the campaign failed to reach that part of the population to whom it might have been most useful. TV and radio were the respondents' preferred media for future campaigns, although again the official language used in these probably meant it would be but poorly comprehended by dialect speakers.

See also; Ho H S, 1979, **Assessment of the effectiveness of a health education campaign in a Singapore urban community,** in Health Education Council, Abstracts: 10th International Conference on Health Education.

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

Account of the setting-up of village health committees in south central Cameroon, with a discussion of methods used, activities and accomplishments of the committees in relation to latrine building, protected springs, garbage pits, and animal enclosures. The evaluation related only to numbers of activities undertaken (and not to the impact on health attitudes, health-related behaviour or health status) and to some subjective assessments of the committees' work. The article is useful, however, for its analytical approach, and the discussion at the end on the implications of such experiments for overall development, for national health planning and services, among other things, could be useful to many other countries, especially those in Africa.

See also; Isley R B and Martin J F, 1977, **The village health committee: starting point for rural development,** WHO Chronicle, 31, 307-315.

Jabre B, 1981, **Innovative approaches in nutrition education in the Pacific region,** International Journal of Health Education 24 (2), 95-101.

The decline of local food production and the rise in the consumption of nutritionally inferior imported foodstuffs is leading to nutritional problems for the Pacific islanders. A nutrition education programme stressing the local resources is being undertaken by the South Pacific Commission using trainees sponsored by community-based organisations and utilising existing groups such as women's village committees as well as health education in schools and radio programmes.

Jenkins J, 1982, **Media for health education,** International Extension College, Cambridge, 124 pages.

This book is aimed at people in developing countries who are interested in health education using media. Written by an expert in distance or non-formal education, it is especially geared to health educators who want to find out more about educational methods. The book is therefore an introduction to methods which make use of media. One section is devoted to descriptions of projects around the world which are helpful in considering the arguments for and against using media for health education purposes. The other main section is a practical guide to implementing such programmes, which gives clear guidelines on the planning, production, organisation and administration of possible projects. Essential reading for any health educator who wants to make the best possible use of media. Available from: 18, Brooklands Avenue, Cambridge, CB2 2HN, U.K.

Kidd R and Byram M, 1978, **Popular theatre as a tool for community education: four case studies from Botswana,** Assignment Children, UNICEF, 44, 35-65.

This is an interesting look at participatory theatre as the starting point for educational programmes and as an accompaniment to ongoing problem-solving by the communities involved. It has interesting potential for community health education, especially in its attempts to involve audience members actively.

Leathar D S, Hastings G B, and Davies J K, (eds) 1981, **Health education and the media,** Pergamon Press, Oxford, 561 pages. Proceedings of Edinburgh Conference held in 1981.

The conference was organised jointly by the Scottish Health Education Group and the Advertising Research Unit, University of Strathclyde. Papers are organised into three main groups: theoretical issues; development of materials; and evaluation. Many of the papers address themselves to health problems more common in the developed world: cigarette advertising; alcohol abuse; breast cancer screening; and tend to assume the availability of high-technology media. However, the whole conference provides a useful overview of the media in health education. Delegates agreed that as it had been used to date, the mass media's power to change behaviour had been over-estimated. Campaigns that had worked well had done so because they were conducted in communities motivated to improve their health, they were co-ordinated campaigns, they were backed up by self-help groups and they had specific aims. The importance of political will in opposing anti-health advertising and commerce was stressed by delegates.

Moynihan M and Mukharjee M, 1981, **Visual communication with non-literates: a review of current knowledge includlng research in northern India,** International Journal of Health Education 24(4), 251-261.

This is an interesting discussion on the importance of health education material being culturally based and tested locally. Many people cannot understand pictures and much thought has to be given as to how to present information. Thus centralised development of materials by professionals, especially in large or culturally diverse countries like India, is criticised. The authors argue strongly that pictorial content of health education materials has to be adapted to the region, where clothing, utensils and buildings vary. The authors have identified 14 concepts which convey all desired information to traditional midwives. For example, the most popular sign for "good" was a parrot and for "danger" a snake. Working with the people, to discover what is understandable and relevant, is essential. Useful for those concerned in production of materials.

Ram E R, 1978, **Realisation of an integrated health services programme in rural India,** Contact 44; 1-15, Christian Medical Commission, World Council of Churches, Geneva.

The author describes a three-year project, from 1973, in Maharastra State, India, in which district, voluntary and church organisations worked out a system of co-operation to provide basic and non-overlapping health care to the rural population. There was an interesting integration of traditional midwives and medical practitioners and a strong element of community involvement in the health education and more general self-help aspects.

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 evaluation of some selected nutrition orientated telecasts transmitted under SITE (the Indian Satellite Instructional TV Experiment programme) is a timely reminder of the need for thorough local information and planning preparation if high technology media are to be of any use in community health education. In this case the telecasts signally failed to reach a reasonable proportion of the target group - rural women of childbearing age - for fairly simple social reasons. The main one was that they were broadcast at a time when most women, having returned from the fields, were engaged in their cooking and domestic chores. The study highlighted the need for: improved quality in telecasts; greater research into the felt needs and social/work patterns of the target populations; the development of a supportive/follow-up infrastructure based on face-to-face communication.

See also; Ramadasmurthy V, 1979 **Nutrition education** and SITE telecasts in Health Education Council: Abstracts: 10th International Conference on Health Education.

Ross D A, 1979, The **village health committee - a case study of community participation from Sierra leone: the Serabu hospital villae health project,** Contact, 49, 1-9, Christian Medical Commission, World Council of Churches, Geneva.

This is a clearly written-up project with evaluation techniques built in at the early stages, involving three villages (others to be added later) in the area of a church hospital. the main aim is "to decrease the prevalence of disease by motivating the people to adopt practices which promote health". The main method is the liaison of village-selected village health committees with staff provided by the hospital as advisers/educators/participators in the village locus.

Scotney N, 1981, **We must stop ignoring local culture,** World Health Forum 531-532.

Increased numbers of properly-trained health education workers, rooted in the local cultures and sympathetic to indigenous customs, attitudes and felt needs, have enormous potential in contributing to the development, improvement and extension of maternal and neo-natal care services in the developing world. The author believes the touchstone in training and approach lies in effective two-way communication leading to the establishment of co-operative he/she serves and between health education worker and the health staff providing the health services.

Sikes O J, 1979, **Education in family planning: what route to take? What difference does it make?** International Journal of Health Education, 22(4), 206-210.

This is a useful article on different approaches in family planning education with examples of increasing use of the mass media for providing the information necessary for informed decision-making. Concludes that neither a "grassroots" nor a "top down" approach is the sine qua non of programme success but that what is needed is a combination of the most important elements in the two approaches.

Sutherland I (ed), 1979, **Health education: perspectives and choices,** George Allen and Unwin, London, 273 pages.

The book is made up of 12 individual contributions designed to cover a wide variety of aspects of health education, each raising its own problems and posing its own questions. Although largely geared towards the industrial world, especially

the United Kingdom, several of the chapters have wider analytical and practical application.

Tones B K, 1977, **Effectiveness and efficiency in health education: a review of theory and practice,** Occasional paper produced for the Scottish Health Education Unit, 90 pages.

This is a very useful critical approach of the current state of health education in Britain. Part one outlines the nature and scope of health education and analyses the logical argument for utilising educational and behaviour modification strategies to improve the health of the community. Part two provides selected examples of a range of health education programmes which have been evaluated and where some degree of effectiveness has been documented.

Tonon M, 1978, **Models for educational interventions in malnourished populations,** The American Journal of Clinical Nutrition 31 Dec., 2279-2283.

This is a good short article. It compares two models underlying community educational interventions:

(a) rational empirical model - basically informating-giving using an instructional method, which is easy to plan for but shows little result in effecting planned change in developing countries;

(b) normative re-educative model - requiring analysis of target groups, a holistic approach, and full participation of the groups with the professionals at all stages of planning and implementation. It is harder to plan clearly for, but more flexible and with a higher success rate. The second type of model is recommended for developed and developing countries.

Tumlison G, 1977, **An exercise in dental health education,** Papua New Guinea Medical Journal, 20(3), 125-130.

This is a description of an effective dental health education exercise trying three different methods to improve the oral hygiene of schoolchildren in Papua New Guinea. It was clear from the results that the only method that brought any improvement was when the teachers and their families were involved, as well as the students. The teachers were motivated by a two-day visit from the dental officer when he explained the causes of decay, examined families and gave individual instruction for cleaning teeth. The schoolchildren were then shown how to clean their teeth, and teachers supervised toothbrushing every day at the beginning of the health class. There was a dramatic rise in cleanliness and gingival health.

Weiss E and Udo A A, 1981, **The Calabar rural maternal and child health/family planning project,** Studies in Family Planning, 12(2) 47-57.

This evaluation of a family planning project in Nigeria has an interesting section on language and communication about family planning, which has implications for education in modern family planning techniques and the sort of cultural constraints which might be met.

WHO Regional Office for Europe, **Principles and methods of health education,** Euro Reports and Studies No. 11, Copenhagen, 1979.

A report on a WHO working group on health education held at Dresden in October 1979. Report deals with the philosophy, principles and methods of health education in industrialised developed Western (European) societies. It contains some comments on the training of health education personnel and the importance of health legislation and an integrated approach.

World Health Organisation, 1981, **WHO/UNICEF regional workshop on information education and communication on health,** Manila, Philippines, 17-23 March, Final Report.

This is a useful synopsis of activities in the region. Available from the WHO Regional Office for the Western Pacific, Manila, Philippines.

Action/Peace Corps, 1978, **Community health education in developing countries: getting started,** 215 pages. American Public Health Association International Health Programmes, 1015 Fifteenth Street, NW, Washington DC, 20005 USA.

A how-to-do-it manual simply and clearly laid out for the guidance of teachers, agricultural extension workers, social workers and other community-involved personnel who want to set up and carry through community health projects. It is divided into four parts: helping a community to start a health project; planning, implementing and evaluating community health projects; some aids and methods in health education; and common community health problems. The emphasis throughout is on community involvement and communal problem-solving. The health education section considers individual and group educational methods, visual aids and mass media, and covers a variety of techniques from songs, dramas and puppet shows through to films and radio.

Asian Community Health Action Network, Flat 2A, 144 Prince Edward Road, Kowloon, Hong Kong.

Community health is the major focus of this organisation. They produce a newsletter called **LINK** which aims to exchange ideas on community health; health information is one aspect sometimes covered.

Bureau of Health Education, Centre for Diseases Control, Public Health Service, U.S. Department of Health, Education and Welfare. The Bureau produces a monthly publication called **Current awareness in health education.** It contains abstracts of documents and descriptions of programmes arranged in chapters according to their major subject area. There is a chapter on "Community health education".

Fuglesang, Andreas 1973, **Applied communication in developing countries: ideas and observations,** The Dag Hammarskjold Foundation, Sweden, 124 pages.

A useful handbook of ideas and practices in communication in the developing world with some sound warnings on the pitfalls awaiting the "expert". See also the useful paper by Fuglesang in the use of folk rather than mass communication media in 1980, in **Health education by TV and radio,** Meyer M, (ed).

Fuglesang, Andreas, 1982, **About understanding: ideas and observations on cross-cultural communication,** The Dag Hammarskjold Foundation, Uppsala, Sweden.

Designed for workers in adult education, primary health care and nutrition, this is essentially an up-dating and expansion of Fuglesang's earlier work on information, cross-cultural communication and adult education in the Third World.

Health education index, 1980, from B. Edsal and Co. Ltd., 36 Eccleston Square, London, SW12 1PF.

Lists over 500 sources of supply and classifies over 9,000 different items. Covers leaflets, film strips, slides, tape cassettes and video cassettes, film etc. Hundreds of wall charts and posters are illustrated in miniature.

Hilton, D, 1981, **Health teaching for West Africa: stories drama, song,** MAP International, P O Box 50, Wheaton 1L60 187, USA, 30 pages.

Developed by a medical missionary in Nigeria, from experience gained in a rural health training school, this booklet offers a simple and practical guide to developing health teaching using the strong locai oral traditions of story-telling and parable, drama and song. These techniques have proved to be popular, flexible in incorporating local custom and effective. Example stories, lessons and ideas are offered for the topics of malaria , diarrhoea, intestinal parasites, latrines and malnutrition.

See also: Barrow, R Nita, 1977, **Rural basic health services: the Lardin Gabas way.** Contact 41. October, Christian Medical Commission, World Council of Churches.

This describes the Lardin Gabas Health Programme, with its community participation village health committees, and use of traditional story telling as a teaching method.

Kemp J E, 1968, **Planning and producing audiovisual materials,** Chandler Publishing Company, California.

A basic handbook on the planning and production of audio-visual materials from posters and charts to films.

Ministry of Health, Zimbabwe/UNICEF, 1981, **Baby feeding: behind and towards a health model for Zimbabwe,** Department of Nutrition, Ministry of Health, Harare, Zimbabwe, 62 pages.

An excellent and well-illustrated little booklet which makes the case against the promotion and use of infant formula while promoting breast-feeding and the use of local foodstuffs as supplements to weaning foods. A broad front of actions to protect and promote breast-feeding is suggested, including implementation of the WHO code of marketing of breast-milk substitutes, putting feeding-bottles and teats on prescription, and giving working women the means of breast-feeding during the hours of work. Although designed specifically for Zimbabwe, the clear and forthright style of the booklet and the thoroughness of the case it makes against commercial breast-milk substitutes suggests its modification and adaptation to the particular circumstances of other countries.

Non-formal education and health: a selected, annotated bibliography, 1981, Non-formal Education Information Centre, College of Education, Michigan State University, East Lansing, Michigan 48824, USA., 56 pages.

A useful annotated bibliography of some of the recent (post-1975) literature in the area. It contains full addresses for obtaining some of the, as they describe it, more "fugitive" materials. The seven-page section on health education is one of the nine parts, and is itself subdivided into: general, manuals, practical materials, guides and radio, TV and audio cassettes.

Population: an international directory of organisations and information resources, a resource book on all aspects of population and family planning, brought out by the Public Affairs Clearinghouse, Claremont, California.

Saunders D J, 1974, (revised 1979) **Visual communication handbook, teaching and learning using simple visual materials.** United Society for Christian Literature, Lutterworth Educational, Guildford and London.

Simple and clear. A basic manual on the communication of ideas through a wide variety of methods from pictures and posters, through puppet shows and drama to a how-to-do-it of projection screens. Much of the book is based on ten years experience in rural India.

Scotney, N, 1976, **Health education,** Rural Health Series 3, African Medical and Research Foundation (AMREF), Nairobi, Kenya, 141 pages.

Useful short book, largely written for health workers in health centres, with one chapter on community health education.

The sun, water and bread, 1978, Report on an appropriate technology workshop in food and nutrition for family welfare educators and home economists, Ministry of Health, Botswana.

Account of a useful workshop in which participants were involved in trying out the many ideas generated in the villages and with the villagers. Useful sections on communication problems and the use of popular theatre and song followed by discussion.

UNESCO, **Reports and papers on mass communication,** Paris.

Ongoing series of useful papers and reports dealing with individual projects or general issues in mass communication for the dissemination of information and education.

Voluntary Health Association of India, 1977, **Better child care,** Safdarjung Development Area, New Delhi.

A small basic booklet, produced in English and several Indian languages, on guidelines to child care, with ample photographs, designed as an aide-memoire and teaching aid for community health workers, but also for a personal use by village families with a literate member.

Werner D and Bower B, 1982, **Helping health workers learn.**

This is a book of methods, aids, and ideas for instructors at the village level, especially for use where there is no doctor.

WHO-AFRO, Technical Report Series No 10, Brazzaville.

Contains a report of a meeting on Commonwealth Sciences for Health Promotion held in Brazzaville July 1979. The meeting reviewed health information and education activities of countries in the region, identified methods and techniques suitable for community health information and education, and worked out a strategy for integration of health information and education into primary health care programmes.

World Health Organisation 1981. **Health education methods and materials in primary health care,** Appropriate Technology for Health Newsletter 10, 24 pages.

A series of brief articles illustrating a wide variety of higher education techniques and materials currently being used in health education programmes throughout the developing world.

African Regional Health Education Centre, Department of Preventive and Social Medicine, University of Ibadan, Nigeria.

Set up in 1975, supported by UNICEF, the Ford Foundation and WHO. Trains health educators from other African countries and produces some interesting reports on projects in the field.

AHRTAG: Appropriate Health Resources and Technologies Action Group Ltd., 85, Marylebone High Street, London W1M 3DE.

Concerned with the development of equipment and techniques for health care at community level. Community health education is one of its special interests - along with dental health, diarrhoeal diseases, disability prevention and rehabilitation. Information services and publications, including Diarrhoea Dialogue.

AMREF: African Medical and Research Foundation, Wilson Airport, PO Box 30125, Nairobi, Kenya.

Produces, among other things, books, manuals and journals for front-line health workers, especially relevant to East Africa.

BLAT: The British Life Assurance Trust for Health Education, Blat Centre for Health and Medical Education, BMA House, Tavistock Square, London W.C.1.

Library, materials and information service on the training of health workers.

Child-to-Children Programme, Institute of Child Health, University of London, 30, Guildford Street, London, WC1N 1EH.

A wealth of data, in several languages, for teaching older children who care for young children how to do more. Applicable to normal and handicapped children. Newsletter and information sheets.

Clearinghouse on Development Communication, 1414 Twenty-Second Street, NW Washington DC 20037, USA.

Information services; publications; including a quarterly newsletter; training workshops and seminars in communication. "Project profiles" on various AID projects.

HEMIS: Health Education Materials Information Service, Centre for Medical Education, University of Dundee, Dundee DD1 4HN, U.K.

An information retrieval service which will provide a comprehensive guide to audio-visual material available on any specific health education topic. The

service is intended to be of value to all concerned with the promotion of health. There is a service charge.

The Health Education Council, 78 New Oxford Street, London WC1A 1AH, U.K.

Has a resource and information library with a complete section devoted to audio-visual aids and materials, lists of films and tapes available. Also a shop with books, leaflets and posters on all aspects of health education relevant to developed Western world with some pamphlets and posters in the languages of ethnic minority groups in Britain - Bengali, Gujarati, Hindi, Punjabi, Urdu, Spanish, Italian, Greek.

International Council for Adult Education, 29 Prince Arthur, Toronto, Canada, M5R182.

International council that produces work of relevance to health education. One example is the Participatory Research Project, an annotated bibliography, December 1977.

International Development Research Centre, Box 8500, Ottawa, Canada, K1G3H9.

Publishes **Low-cost Rural Health Care** and **Health Manpower Training,** an annotated bibliography with special emphasis in developing countries, which includes entries on health education.

International Extension College, 18 Brooklands Avenue, Cambridge, CB2 2HN, U.K.

Information, materials and expertise on all aspects of distance learning.

IPPF: International Planned Parenthood Federation, 18-20 Lower Regent Street, London, SW1Y 4PW.

They publish **IPPF Co-operative Information Service,** a booklet with a constantly up-dated list of references and addresses in the whole area of family planning and population.

IUHE: International Union for Health Education, 9 Rue Newton, 75116, Paris, France.

Parent organisation for the international conferences on health education.

Non-Formal Education Information Centre, College of Education, 237 Erickeson Hall, East Lansing, Michigan 48824 USA.

Produces the **NFE Exchange,** occasional papers in various fields, including health. See in particular, **Non-formal education and health: a selected annotated bibliography,** 1981.

TALC: Teaching Aids at Low Cost, Institute of Child Health, 30 Guilford Street, London, WC1 1EH.

Provides low-cost sets of slides and books to help in teaching.

United Nations Information Centre, 14-15 Stratford Place, London, W1N 9AF.

Library and reading room.

VISITS

In the three countries visited many people gave up valuable time to help us accomplish our mission. The list below does not do justice to the many villagers, health education personnel, other health workers, teachers, pupils and volunteers who welcomed us and patiently answered our questions. Thanks and appreciation to all.

SRI LANKA

Dr Munasinghe,	Director, Health Education Bureau
Dr Abeyagunewardene	Health Education Bureau
Dr Fernando	Health Education Bureau
Mr Karunadasa	Health Education Bureau
Dr Malalasekara	Health Education Bureau
Dr Perera	Health Education Bureau
Mr Ranaweera	Health Education Bureau
Mr Saparamadu	Health Education Bureau
Mr Wijetunga	Health Education Bureau
Dr Goonesekere	Family Health Bureau
Mrs Jayasinghe	The Women's Bureau
Dr Jayasuriya	Planning Unit, Ministry of Health
Dr Senevirutne	Medical Officer of Health, Padukka

TANZANIA

Dr Mtera	Director for Preventive Services, Ministry of Health
Mr Chizenga	Health Education Unit
Ms Assay	Health Education Unit
Mr Khihange	Health Education Unit
Mr Mandange	Health Education Unit

Ms Matole	Health Education Unit
Mr Ktavangu	Health Education Unit
Mr Mwango	Health Education Unit
Mr Hegga	Radio Tanzania
Mrs Ngaza	Tanzania Food and Nutrition Centre
Mr Dhalla	Planning Unit, Ministry of Health
Dr Shoo	Continuing Education Unit, Ministry of Health
Professor Nhonoli	Commonwealth Regional Health Secretariat, Arusha
Dr Maikambo	Family Planning Association
Mr Mbeleka	Family Planning Association
Mrs Mtawali	Family Planning Association
Dr Ng'Wandu	Director, Institute of Adult Education
Professor Takulia	Community Medicine Division Muhimbili Medical Centre.

CYPRUS

Dr Angastiniotis	Cyprus Thalassaemia Centre
Dr Hadjiminas	Cyprus Thalassaemia Centre
Dr Markides	Director of Department of Medical Services, Ministry of Health
Dr Komodiki	Department of Medical Services
Mr Charalambous	Department of Medical Services

Thanks also to the British Council and Turkish Cypriot health personnel who made possible a brief visit to the general hospital in the north of the island.

Printed and published by
The Commonwealth Secretariat

May be purchased from
Commonwealth Secretariat Publications
Marlborough House
London SW1Y 5HX

ISBN 978-1-84859-358-9