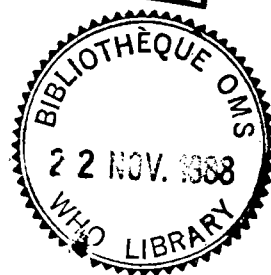


INFORMATION AND EDUCATION FOR HEALTH IN SOUTH-EAST ASIA

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WORLD HEALTH ORGANIZATION
Regional Office for South-East Asia, New Delhi

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FOREWORD

Information for health and education for health have been the subject of discussions and review by WHO leadership for sometime now. Enshrined in the WHO Constitution is an important principle that "Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people". More recently, the primary health care strategies spelt out even more forcefully that to achieve the goal of Health for All (HFA), people's action leading to self-determination and self-reliance is vital. If people are to participate, as this implies, in national health development it is important that they must as a beginning be well informed.

But information alone is not enough. People must also be educated on how well they can use that information to express their needs and make reasoned choices to avail of the opportunities to attain health in partnership with their providers and with each other. At the World Health Assembly held in 1982 it was decided that information for health and education for health must be integrated. Following this, in the South-East Asia Region of WHO, Information and Education for Health (IEH) has emerged as an important strategy towards achieving the goal of Health for All.

An awareness has begun. The conventional health education models of the yester-years are being questioned. A new relationship is building up between health care providers and the community demanding a constant two-way flow of information between decision-makers and people. IEH is developing to catalyze this relationship through a range of multisectoral activities carried out by health professionals, behavioural scientists, educationists, information specialists and the mass media. IEH is developing to enable people to identify themselves with the HFA movement, to attach a value for health, to plan and to act in partnership with the health services and with each other for the attainment of health.

The IEH focus in totality, both globally and in the South-East Asia Region, has thus in many ways been instrumental for the production of this book. It should enable the reader to look at IEH and its need against the backdrop of the Organization's HFA philosophy and to obtain a bird's eye view of the overall development of IEH in the Region, highlighting both its strengths and weaknesses. It is hoped that this may prompt readers to make

a critical assessment of IEH in their countries and to think about plans, strategies and active measures to further strengthen and develop their IEH programmes. "The Future Perspective" as presented in this book provides to readers some food for thought in this direction.

The publication of this book comes at a time when the fortieth anniversary of WHO is being celebrated all over the world, not just on World Health Day, but throughout 1988. IEH will play an important role in this historic event both within and between countries of the Region.

It is hoped that this book will further inspire IEH development in the Region to bring Health for All before the close of this century.



Dr U Ko Ko
Regional Director

PREFACE

The new thrust and sense of urgency given to health activities in the wake of the call for Health for All by the Year 2000 had a logical sequel – the incorporation of information into the education for health programmes.

“Information and Education for Health” emerged to enlarge considerably the scope and reach of health programmes all over the world. This document attempts an overview of how this important emerging feature, under official prodding, has indeed evolved and developed in countries in WHO’s South-East Asia Region, against the backdrop of the WHO philosophy and its primary health care strategy. It also tries to put forward a perspective for the future.

The document is largely based on reports available in WHO’s South-East Asia Regional Office. Information and Education for Health (IEH) is neither a separate entity, nor is its operation defined in the formal health education structures existing in the countries of the Region. The overview thus relies on information collected from the official reports of the countries and their health education development programmes. The future perspective is extrapolated from what these countries are already doing, intending to do, or possibly can do, in the next few years, to create an informed and motivated public who will actively participate in the Health for All movement. It incorporates views expressed in documents prepared in the WHO Regional Office and the recommendations made at its various country, inter-country and regional meetings.

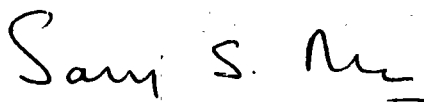
In presenting the future perspective, I have also drawn heavily on the views and concerns expressed to me at various times both by experts and by the community with whom I have had the privilege of working and sharing my ideas over the past three decades of my involvement with community health teaching and practice.

There were of course various limitations, not the least being inability to make an on-the-spot assessment and study, and it is thus more than possible that the sharper details needed to complete the IEH profile in the Region got left out. In many ways, this document is only the beginning, an outline which hopefully will develop into a better-filled, more elaborate, visual canvas as time goes by. In completing this canvas, users of this document

may have so much more to add, especially their aspirations, their successes and their future plans for IEH implementation, in support of Health for All by the year 2000.

I am very grateful to Dr U Ko Ko, Regional Director of WHO's South-East Asia Region, for sharing with me his most stimulating views on the responsible role of IEH towards achieving the goal of Health for All.

WHO will complete, in 1988, four decades of its work in international health development, in the fight against disease and in the promotion of health. In all humility I dedicate this book to the 40th Anniversary of WHO.

A handwritten signature in black ink, reading "Saroj S. Jha". The signature is written in a cursive style with a horizontal line under the name.

Dr Saroj S. Jha

1. INFORMATION AND EDUCATION FOR HEALTH IN SUPPORT OF HEALTH FOR ALL BY 2000 A.D.

The Beginning

In the preamble to the Constitution of the World Health Organization adopted in 1946, it is stated that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

In 1977, at the World Health Assembly, this aim was given full perspective. More than 150 Member States of the Organization adopted a resolution deciding that "the main social target of governments and WHO in the coming decades should be the attainment by all citizens of the World by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" (Resolution WHA 30.43), popularly known as "Health for All by the Year 2000" (HFA/2000).

In 1978, in a unique collective expression of political will in the spirit of social equity and justice, the International Conference on Primary Health Care held in Alma Ata in the USSR issued the historic Declaration of Alma Ata which stated clearly that Primary Health Care (PHC) is the key to attaining the target of HFA/2000, primary health care being defined as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally acceptable to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development, in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health process."

The global policy conveys in no uncertain terms that, for the realization of Health for All (HFA), there must be a joint commitment between governments and the people. Governments have a responsibility to provide for the health of their people. On the other hand, people have the right and

the duty to attain health through community and individual self-reliance and participation in the planning, organization, operation and evaluation of PHC making the fullest use of local, national and other available resources. Education must form the starting point of this joint commitment – education at all levels – for policy makers, planners, professionals and the people.

It is thus understandable that, as defined by the Alma Ata Declaration, “Education concerning prevailing health problems and the methods of preventing and controlling them” appears first on the list of the essential elements of primary health care.

1.1 The Early Years of Health Education

Health education, as an integral component of national health programmes, was, in fact, being practised, long before the Alma Ata Conference. The first meeting of the WHO Expert Committee on Health Education, which was held in 1954, recognized that health education involved working with people, enlisting their goodwill and participation.

In the Region, central health education bureaus were established that trained personnel, provided technical guidance in all health education matters and prepared and produced health education materials. Impressive health education infrastructures were developed in some of the countries of the Region as a result of the pioneering efforts of a number of committed and dedicated health professionals. With training and manpower development programmes, qualified health educators became available to staff the health services organizations in the countries. Media support was also enlisted and a variety of health education materials, like posters, flip charts, slides, films, etc., were used to convey health messages.

Health education approaches, however, remained largely confined to the health sector and to the health service providers, instructing individuals and groups as to what to do and what not to do to prevent illness. This top-down one-way communication process did not permit for people’s participation, for a wider understanding of people’s health perceptions and specially their values both traditional and acquired for effecting a behaviour change. The favoured Knowledge, Attitudes, Practices (KAP) health education models thus failed. Its widest and earliest application in the area of family planning bears testimony to this. Obviously the relationship between knowledge and

practice turned out to be much more complex. Design and production of health education materials also became largely a centralized activity. Its effectiveness was questioned when used in situations where the social, cultural and psychological dimensions of the health behaviour of communities living in those areas were not considered at the time of conceptualising the communications strategies and health messages. Health education also did not attract sufficient funding as a support programme. Within the health services structures where hospital and curative services devoured most of the health budgets, health education, like other promotive and preventive health activities, did not receive the priority it deserved.

The outlook, however, changed when approaches to health care started to change. Voluntary agencies first demonstrated this in the seventies. The Solo Project of Indonesia and the Jamkhed Project in India, with their charismatic leadership, paved the way for a new health perception. 'Health by the people' became an achievable proposition.

A shift from a "medicalized" view of health to one which viewed health and ill-health in the context of the socio-cultural-economic-political milieu began to take place. With fresh insights into epidemiology, rising social expectations and the new realization for the need of public involvement in health issues, health care strategies now began to focus on people's development. It was simultaneously realized that, for the strategies to succeed, inputs from sectors other than health were essential.

One of the basic principles in the Organization's HFA strategy clearly states that "an acceptable level of HFA/2000 cannot be achieved by the health sector alone. It can only be attained through national political will and the coordinated efforts of the health sector and relevant activities of other social and economic development sectors." It also states that "measures will have to be taken to ensure free and enlightened community participation so that individuals, families and communities assume greater responsibility for their own health and welfare, including self care." It is within this principle that health education must be perceived and developed.

1.2 New Approaches to Health Education in Primary Health Care

A WHO Expert Committee met in Geneva in 1982 to have a fresh look at health education, especially in view of the many developments that had

taken place in primary health care strategies and in the field of social sciences and mass media technology. The Director-General of WHO had clearly outlined five areas in health education where new thinking was required. These were :

- (1) New policies in harmony with HFA/2000 and PHC.
- (2) Development of human resources with the skills to translate social goals into educational objectives for HFA/2000.
- (3) Reflection on educational technology most appropriate to promote individual and community involvement and self-reliance.
- (4) Strengthening of multi-sectoral approaches and increased coordination of health efforts through appropriate technology.
- (5) Greater attention to monitoring and evaluation.

The models and structures of health education developed over the years were found to be no longer relevant. To create in people "informed opinion" and "active cooperation", it was felt that larger, more extensive information channels to reach wide sections of the people must be used. Also, health education could no longer be considered as the monopoly of the health sector; inter-sectoral involvement and spread was essential.

The early paternalistic command-like approach taken by health workers and health education specialists chiefly through classroom learning processes was found inappropriate. In the new relationship building up between communities and health care providers, it was being increasingly realized that individuals have the potential capacity to make a reasoned choice from among alternatives to improve their own health and the health of other citizens, irrespective of their social standing. This people oriented health technology implies that people will no longer be fitted into a pre-determined framework of health care. Members of the community must play an active role in the planning and setting up of a health-care programme and health-care providers must, on their part, understand thoroughly the health culture and life-styles of the communities they service and how these are influenced by the dynamics of social and cultural changes and by the political and economic organizations. This approach demands a constant two-way flow of information between decision-makers and people, encouraging

the development of effective education programmes involving inter-sectoral collaboration, use of media and people's participation.

1.3 Information and Education for Health

After considerable deliberations, it was decided at WHO that information for health and education for health should be integrated, for they are after all the "two wheels of the same chariot pushing towards the HFA goals with activities ranging from advocacy for health arousing public consciousness and reaching key segments of the public through various types of media, both modern and traditional, to an approach involving an inter-personal dialogue dealing with specific individual and community aspirations and problems on health". The nomenclature adopted by WHO at the Thirty-fifth World Health Assembly in 1982 "Information and Education for Health" (IEH) brought into focus a broader perspective inherent in the meaning of PHC: for PHC to succeed, it will require not only the support of the health system, but of all other social and economic sectors and with active community participation. IEH thus calls for a mutually supportive use of all sectors in community development efforts, communications, and especially mass media to advocate health at all levels, including policy and decision-making levels, to mobilize professional and social support for HFA/2000 and to inform and educate people to develop skills to recognize, solve and control their health problems.

The need for an accelerated progress in IEH activities is urgent if HFA deadlines are to be met—by initiating social mobilization for health through favourable political will, social involvement, and action at individual, family and community levels.

In the Seventh General Programme of Work of WHO (1984-1989) and in the draft of the Eighth Programme (1990-1995), it is stated that one of the objectives of WHO will be to foster education and information activities, which will encourage/motivate people to want to be healthy, to know how to stay healthy, to seek help when needed and to do what they can individually and collectively to maintain and promote health in a dynamic interaction and partnership with the health services.

IEH commitment in the South-East Asia Region of WHO (WHO/SEAR) is equally strong as reflected in its medium-term plan (1990-1995). Technical

discussions on IEH were held in conjunction with the fortieth session of the Regional Committee in 1987 and the recommendations made to strengthen IEH were fully endorsed by the Regional Committee.

IEH in support of HFA/2000 has thus emerged as an important activity for the countries of WHO/SEAR, an activity that is hoped to be promoted and strengthened in the Fortieth Anniversary Year of WHO in 1988 and accelerated further during the Region's march into the twenty-first century.

2. AN OVERVIEW OF IEH DEVELOPMENT IN COUNTRIES OF WHO/SOUTH-EAST ASIA REGION

An overview of the development of IEH in the countries of the South-East Asia Region of WHO reveals some very positive developments that have been taking place, but, at the same time, also shows up underdeveloped areas that need urgent attention. IEH is 'catching on' in the Region. There is the beginning of a realization that, to attain HFA, people need to be informed and educated. Similarly, media specialists are being involved, linkages between the health and information sectors are being made stronger and there is now much greater use of mass media channels to implement IEH. There is also an increasing realization that sectors other than health can and should get involved in producing an informed public who will participate in the movement of HFA/2000. Services are being expanded to train larger groups in the community to deliver IEH, to make training multi-disciplinary, to augment training facilities and to improve the quality of training content, training methods and training materials. Community level health functionaries and other key persons like teachers, religious leaders, etc. are increasingly being involved in the delivery of IEH. But, there is still a lot to catch up. Generally in the countries of WHO/SEAR, IEH activities are not being consciously planned. They are still largely seen as activities confined within the narrow health education organisation existing in the countries. The various technical jargon that have developed in the field of communication is also causing confusion. There is little unanimity about the meaning of the various terms in current usage like Information, Education and Communication (IEC), Development Support Communication (DSC), Information, Motivation and Communication (IMC) and Information and Education for Health (IEH). In many countries, there has been no serious attempt to make IEH anything other than synonymous with 'health education', and health education has had its limitations. Although listed as one of the essential components in the country's PHC programmes, budgets allotted to health education are low, ranging from 0.60% to 2.3% of the overall health budget in most countries. Although this per se may not reflect the importance or non-importance given to health education, there are reasons to believe, as revealed by situational analyses, that health education has not received the priority it deserves, both in the planning and implementation of health programmes.

2.1 Health Education Organizations

A structured health education organization exists in nearly all of the countries of WHO/SEAR. Its outreach to peripheral levels is however yet to develop fully.

It must be recalled that an early failing of the entire health services organization in the countries of the Region has been the blindfolded acceptance of western norms and ideals in the planning and provision of health-care facilities for the people. This meant establishment of curative health services based on imported technologies, doled out from central urban institutions, with little trickling down to areas where it was most needed.

Health education too has followed the same pattern. To develop an institution at the top-most level was the first step in the formalized health education services of the countries. The job of public information on health rested with health education bureaus, set up by the Ministry of Health and established at the country's centre. These bureaus were distant from the people living in peripheral areas. Gradually over the years, the health education infrastructure has however spread out to more distant levels. Except for Bhutan where a health education unit has only recently been established at the National Institute of Family Health, an organizational structure for health education services now exists in all countries at the central and provincial levels, and in most countries also up to the district level.

To staff the formal organization-structures of the health education programme, professionally qualified health educators, responsible for the implementation of the health education programmes, are posted. In Bhutan the health department staff themselves take on the responsibility. In Mongolia too, there are no special health education officers. Doctors and paramedical staff, by virtue of a two-month training, take on the health education workers' role. It is firmly accepted in the entire region that, in addition to health education experts, the onus and responsibility of health education rests with all health professionals and functionaries, including community health workers. This is particularly so at sub-district levels and below at the primary health-care levels. There are also several countries which have involved workers other than health workers, in health education, like school teachers and religious and community leaders.

Since health education functions include, very largely, production and dissemination of health education material, most health education organizations have included in their staff, media officers, publicity officers, artists, photographers, visualizers and so on. This is one step towards the development of IEH in the Region. In some countries, behavioural scientists are being recruited. This is encouraging as the contribution of these scientists is valuable in developing more effective communication processes and in directing useful health behaviour research.

2.2 Intra- and Inter-Sectoral Influences

Although health education is seen as an integral part of all health programmes in the Region, its intra-sectoral influences seem limited.

It appears from information available that the relevant IEH inputs into the overall health planning process in most countries in the Region are limited. This could be due to the fact that IEH research, poorly developed as it is, has not generated significantly new knowledge that could influence policies and strategies. Even when some information is available, this may not always be used by planners in their planning processes. To give direction to policies and programmes, and particularly to IEH programmes, feedback from the community is most essential. Due to the non-participatory nature of IEH activities this is also not widely available. National health plans and strategies thus rely mainly on the aggregate statistics obtained through existing health information systems which in many instances do not reflect the real situation and needs of the community. The mechanisms that exist for coordinating health education activities with other health sector activities at the formal structural levels are not clear.

Every health programme – whether it is EPI, nutrition or others – includes to a lesser or greater degree some IEH components in its strategies. The extent to which the health education organization is involved in the planning and implementation of these programmes is not known. Do the health education experts train the EPI managers in the effective use of IEH material? Do media personnel attached to health education units design their material with nutrition strategists?

Much will depend on the formal mechanisms available for such interaction and coordination. It will also depend on the trained manpower available to facilitate such coordination, both within the health sector and between health and other sectors.

Inter-sectoral approaches, on the whole, although recognized, have also been slow to develop. Coordination mechanisms for inter-sectoral collaboration with various ministries, necessary for IEH development, are generally not formalized in most countries. Generally, no institutional arrangement or management process exists for integration of information with education for health.

Some linkages have, however, been established between the health education bureaus and the ministries of Public Information, Education, Agriculture, Women's Affairs, etc., through formation of coordinating committees, meetings, etc. For instance, mass media is getting increasingly involved in the dissemination of health information.

India has established a high-level committee at the level of the Ministry of Health and Family Welfare to coordinate, guide and monitor media programmes in health. In other countries too, interfacing between health and media sectors are increasing. In Thailand, an IEH centre, inter-sectoral in composition, has been established at the central level by the Ministry of Public Health. In many countries health education components are getting included in the formal school curricula and in the non-formal educational training programmes. There are reports of training programmes being held for officers of health related ministries, extension workers, school teachers, etc. and for informal leaders in the community in almost all the countries of the Region. These are significant developments. Their operationalization will, however, depend to a large extent on the formalized organizational linkages they have set up between sectors, the clear-cut demarcation of responsibilities and authority within the committees and, most important of all, a common understanding that has evolved among them on the problem to be addressed, and for whom, through information and education.

The form of collaboration that occurs, if any, at ministerial levels lower than central or provincial ministerial levels, is not known. The coordination and collaboration at the important grassroot levels are ill defined. Even when some fora exist, like village councils and committees, it is not known to what extent functionaries other than health ones provide health information and integrate IEH in their own development area work. It is doubtful whether manuals or other training material are available to such personnel in adequate quantities.

If inter-sectoral cooperation is sought in the dissemination of health information and education, then inputs from these sectors must also be obtained for the planning and the design of communication programmes. There are no indications that this is being done in the Region.

A success story in an intersectoral approach to nutrition education, as reported from Nepal, appears impressive. In 1978, a national nutritional coordinating committee, in collaboration with WHO and UNICEF, developed a set of nutritional strategies which stressed an integrated and coordinated approach involving various ministries. On the basis of this, the joint nutrition support programme for prevention of malnutrition was launched in five districts in Nepal. In this programme, the health sector directs its educational efforts to rural mothers, promoting growth monitoring, immunization, proper feeding habits, personal hygiene, sanitation, etc.

The agriculture sector trains the population in the appropriate technologies of food production and also provides information about the nutritional values of different foods.

The involvement of the education sector is through non-formal, functional literacy programmes and nutrition education in schools. At least one school in each district is encouraged to start projects to grow green vegetables and fruits and raise poultry. Children are also encouraged to participate in the latrine construction programme.

The social welfare ministry directs its activities to women, improving their functional literacy on matters related to agriculture and nutrition and provides supporting structures that facilitate women's economic activities. The Nepal Children's Organization distributes supplementary food in day-care centres and primary schools and educates mothers on the proper utilization of these nutritional supplements.

The public media sector plays its role by using the press, radio and TV to disseminate information on food and nutrition.

The Ministry of Health, WHO and UNICEF are all contributing to this effort through distribution of educational materials, such as flash cards, flip charts, posters and pamphlets

In this inter-sectoral venture, attention is also paid to developing second level and middle level manpower through training of workers of health, agriculture, social welfare, government and non-government volunteer agencies, school teachers and panchayat-based women workers..

2.3 Training Programmes

There are no formal courses for IEH training, although in a number of countries, health education training is available at the central bureaus of health education, in universities and in training schools including post-graduate institutes of health, offering certificate, diploma, masters and doctoral courses.

Health education is integrated in the professional courses for doctors, nurses, environment health experts, etc. Some countries like Nepal, Sri Lanka and Thailand have clearly stated that revisions are being made or plans are afoot to revise curricula to meet HFA requirements.

Some kind of health education training for peripheral level workers is also taking place in countries of the Region through pre-service and in-service training. Different training methods are being used, for example, through role playing in Bhutan for village volunteers, short courses for selected health activists from the community in DPR Korea and for community health workers in Mongolia, orientation training programmes for health guides and school teachers in India and for community leaders and village volunteers in Indonesia.

In Maldives community level health workers are given health education by means of audio-visual aids. Sri Lanka trains non-formal education trainers, and in Thailand a short training programme has been organized for community level health and social service workers.

2.4 Communications Programmes

Most IEH programmes being carried out in the Region relate to communicating technologies directed to child survival, family planning, improving nutrition and managing diarrhoea and dehydration. Generally, the programmes are addressed to women.



An effective form of health and family planning communication leading to free and frank exchange of information is the person to person approach taking place in familiar and informal settings.



Charts and posters to explain and simplify technical information are useful aids even at the most basic level of the health services infrastructures.



A practical dimension to IEH is when skills are learnt through 'doing'. Cultivating kitchen gardens is one example of such an approach.

To a significant extent, school children and teachers also form important target groups for IEH. Community volunteers, religious leaders and other opinion leaders are other target groups identified and addressed.

Production and supply of material for IEH communications is undertaken largely by the central health education bureau and, in the larger countries, also by the health education units at state or provincial levels.

The types of IEH material that were developed in most of the countries of the region have been posters, flip charts, flash cards, stickers, folders, pamphlets, booklets, manuals, slides, tapes, films, etc. carrying messages of family planning, nutrition, immunization, diarrhoea control and other common health problems.

There are no indications that the communities, and particularly the target groups that are addressed, participate in any form in the design of the materials or messages to make them more appealing, acceptable and in general more communicative in a language that is understood. Face to face verbal communication through talks and group discussions is probably the most common method used to channelize IEH.

The indigenous forms of communication, like puppetry, drama, song and dance, etc. are popular in some countries but there seem to be no indications that these channels are being reinforced. Health exhibitions and health fairs are held in some countries. In Thailand, the village public address system is used to channelize IEH and its effectiveness is being evaluated.

The mass media, on the whole, is becoming more and more accessible to the health education organizations for IEH. The radio has the largest outreach in the Region. There are regular health broadcasts for women, school children and the general community. There is however little feedback on the effectiveness of this medium in health communication. In India, UNICEF's efforts to use radio for improving the health of women and children began in 1981-82 using the Integrated Child Development Services (ICDS) as a base. Its results are being evaluated. IEH, through television programmes, is being attempted in a number of countries in the Region. However, in most countries these are not allotted prime time. The recent strategy of the Ministry of Health and Family Welfare in India to popularise the small family norm and universal immunization through TV quickies screened

at prime time seems impressive but needs evaluation. The electronic media has several inherent shortcomings which must be recognized. Apart from the high costs and dependency on electricity, supplies of which are erratic in many of the rural areas of the countries, the programmes also tend to be less culture-specific as they have to cater to wide audiences belonging to varied socio-economic backgrounds and speaking different languages. Its outreach and effectiveness also needs evaluation particularly in the context of the literacy levels of communities. In some countries, like Bangladesh, Nepal, Bhutan and India more than half of the adult population are illiterate. Women, for whom a lot of IEH is addressed, have even lower literacy rates. Even among the literate (literacy being defined as merely the ability to read and write) it is doubtful if the majority also possesses the ability to understand the written word, to think analytically, and to use this knowledge to make decisions.

2.5 Special Focus Areas

The three weakest components in IEH development in the countries of the Region have been in the areas of:

- Community Participation
- IEH Research
- Monitoring and Evaluation

2.6 Community Participation

Involving communities to implement health education programmes planned and conceived by centralized institutions is not community participation. Generally, community participation is seen in this light by those responsible for implementing health education programmes in the Region. Also, the training of community health workers and volunteers to impart health education is taken as one step forward towards community participation. This may be so in a limited way, for the focus is often only on the mechanisms of delivering information, rather than on dialogue, mutual feedback or the community's own identification of health problems and the decisions they make to overcome them. For this, there must be community participation at all levels, in planning, designing, implementing and evaluating health education. Such forms of community participation are unknown in the Region as a whole. There may be reasons for this. The existing political,

administrative and cultural tradition in the countries of the Region have largely been "top-down" and authoritative. The gaps between the haves and have-nots are wide. The poor have internalized that as they are ignorant and helpless, they must depend on "outside" interventions, from people who know and have the power to improve the quality of their lives. Another important reason for poor community participation may be the lack of training of programme implementers in the mechanics of involving communities to participate actively in health development and, most important of all, lack of a clearly defined policy which will empower people to exercise control over the solutions to their health problems.

Participatory approaches are also slow and thus find no place within the usually tight, time-bound workframes of national health programmes.

The Village Level Health Committees in India, the Technical Cooperation among Developing Villages (TCDV) in Thailand and other such fora are positive efforts towards involving communities. Their success will largely depend on the quality of the IEH component in all their activities.

Non-governmental organizations enjoying the freedom of experimentation and flexibility in approaches have been more innovative in this direction. The Comprehensive Rural Health Project in Jamkhed in India has used village health workers effectively in changing health practices in the district through participatory approaches. The Bangladesh Rural Advancement Committee (BRAC) used education as an intervention for diarrhoeal management through village committees, home teaching and mass media and a concurrent evaluation has shown that people's participation had helped push the programme to make the home-based oral rehydration therapy (ORT) acceptable to the people.

2.7 IEH Research

Another weak component in IEH development in the Region has been the area of research. This is understandable since the IEH concept itself is not yet truly operationalized. Except in Thailand and India, there has been little research in health education in the context of PHC. Generally, there are also no in-built organizational supports for IEH research. In India, however, a Research and Evaluation Division is part of the Central Health Education Bureau.

Participatory forms of research are unknown and incorporation of behavioural science research methods has been few and far between. As early as 1973, the WHO Regional Office recognizing the importance of behavioural science research in health education sponsored an inter-country course in this subject. Since then, there has been some interest shown in the various aspects of health behaviour research from time to time through various consultative meetings.

Health behaviour research has however largely been limited to KAP studies and many of these have been conducted mainly in the field of family planning. While KAP studies convey what people know and do, they rarely tell why people do what they do.

Research in the production and use of information and training material and the impact of health education programmes have received very little attention. Only Thailand reports a significant number of studies being carried out on the effectiveness of media and research on programmes directed to control of specific diseases. It is believed that some amount of IEH research is being carried out by departments of community medicine in various universities, but information on this is inadequate. Also, it seems that many of these studies are not followed by intervention programmes.

In a paper presented at the thirteenth session of the South-East Asia Regional Advisory Committee on Health Research, held in 1987, some of the gaps in IEH research development in the Region were identified. It was stated that the capacity to conduct research in IEH and in behavioural sciences in the countries of the Region is limited. Very few health education bureaus in the Region have research units. Health education specialists manning the programme have received inappropriate training in research methodology either for guiding or conducting research studies. Problem orientation is lacking; a lot of research, especially behavioural science research, was conducted as an after-thought to meet social impact requirements and not planned to precede or even accompany a major new activity. Above all, health administrators are not as yet well cognizant of the contribution of IEH research to achieving the goal of HFA/2000. Even when research findings are available, their utilization is poor. Research is isolated from policies and programmes. Mechanisms and resources to synthesize research findings and to disseminate them widely at all levels are also lacking. There are no formal linkage systems to facilitate communication between research workers, policy makers, administrators and the community.

2.8 Monitoring and Evaluation

In the management of IEH programmes, a uniform failing in all the countries of the Region has been the lack of adequate monitoring and evaluation of IEH programmes. Monthly reports and on-the-spot field observations are the common tools currently used. Unlike most other health programmes, where outputs (like immunization coverage or number of cases detected) are tangible and measurable, IEH, because of its complex nature, does not easily lend itself to such audits. Yet, suitable monitoring and evaluation systems need to be devised. Many countries in the Region have experienced this need and are in the process of initiating monitoring and evaluation processes.

3. THE FUTURE PERSPECTIVE

This future perspective for IEH in the Region is based on the situational analysis of IEH development in the Member Countries of the Region, its strengths and shortcomings and their potential capacities and capabilities to further develop and improve.

The future perspective makes the community the nodal point for IEH, and for its active participation in thinking, planning, deciding, acting and evaluating. The objective of IEH in countries should be to raise the health consciousness of the people, by enabling them to perceive their health needs and to develop in them the willingness and desire to generate and disseminate information and knowledge on health among themselves and to the formal health providers.

IEH programmes should impart to the communities the knowledge and skills necessary for influencing decision making and implementation of programmes. The role of mass media and other sectors towards this effort must be understood and implemented effectively. Re-orientation at the top levels may have to take place, but this must take place not merely in response to the demands of a movement being generated from below, but also from a genuine commitment to make HFA a reality in the spirit of equity and social justice.

The future perspective presented in this document can at best serve as a general overall plan, aspects and details of which will have to be considered at the country level, based on the individual country situation, resources and thrusts. It is more than possible that in many countries of the Region, action plans for reorganization of health education structures, for making IEH multi-sectoral, for promoting community participation, for integrating information into education for health and innovative IEH projects in support of HFA/2000 are already underway. The emerging scenario in the next twelve years will tell how far this has been fruitful.

In presenting a future perspective, the importance given to IEH, both globally and by the Region, is especially reflected. The future perspective also projects the Regional Office's own commitments and activities in IEH

development, most prominent of which will be to support national activities to achieve Health for All by the year 2000.

The result of activities at both country and regional levels is what will eventually shape the future scenario.

3.1 Country Perspectives

Enhancing the Understanding of IEH and Its Role in Introducing and Reinforcing PHC Culture

Ten years ago WHO formulated the strategies for HFA/2000 and declared PHC as “the key to achieving an acceptable level of health that will permit all people of the world to live a socially and economically productive life in the spirit of social justice”. Since then every Member Country in the South-East Asia Region of WHO has adopted this goal and strategy. Primary health care projects five principles that are essential for health development. These are:

- (1) equity in health services access;
- (2) active community participation in health decision making;
- (3) focus on preventive and promotive health, rather than on curative services;
- (4) developing, in the health system, appropriate methods and materials for health care that will be relevant and acceptable;
- (5) involving other sectors, like nutrition, education, water supply and shelter in providing health to people.

By now, a PHC culture should have developed in the South-East Asia Region. The question is, “has it”?

The Seventh Report of WHO on the World Health Situation (1986) evaluates HFA strategies in the South-East Asia Region. Patterns and trends in health status in the Member States indicate that there is no room for complacency. In many countries, infant and child mortalities are still alarmingly high and diarrhoeal diseases continue to be a leading cause of mortality in children under 5 years. Malaria and leprosy account for about half of the total world incidence (even though the population in the Region is only 24% of the world population) and prevalence of tuberculosis, a major

public health problem, has remained static over the past ten years. Moreover, more people in the Region suffer from the many and varied forms of malnutrition than in any other region of the world.

It is not as if health care coverage has not expanded. Most Member States report significant progress in reaching out to people through augmentation of health facilities at the primary health care levels. But whether the quality of care and the appropriateness of services have improved is another matter. Besides, as the PHC approach clearly indicates, ill health is not just due to deficiencies in the health sector alone. Ignorance, hunger and the state of the environment are also most intricately connected with disease and disability.

In Bangladesh, Nepal, Bhutan and India, less than half of all males and less than three-quarters of all females are literate. A positive correlation between high literacy levels and improved health status is amply demonstrated even in the Region. In countries like Sri Lanka, Thailand and DPR Korea with high literacy rates, the infant mortalities have declined to levels less than 50 per 1000 livebirths. Apart from low literacy, irrational beliefs and health practices arising out of superstition, magic and quackery have also been serious obstacles in promoting health. Most countries in the Region are also witnessing tremendous population pressures on food. The per capita availability of foodgrains has actually declined in Bangladesh and Nepal. Even in countries where food production has outstripped population growth, like in India, the poor continue to be deprived due to inequitable distribution of available food resources and due to lack of purchasing power.

As far as environmental health is concerned, less than 40% of the population of the Region had reasonable access to safe water by 1980. In rural areas this percentage was much less. Excreta disposal facilities were even poorer, only accessible to about 6% of the rural population.

On the whole, inter-sectoral coordination, an essential determinant for promoting the PHC culture in the Region, has also been slow to develop in the Region. There is a growing awareness of the need to collaborate with information sectors to operationalize IEH. But IEH involves more than just putting information and media specialists together with health experts. IEH involves more than just packaging attractive informational material and having the facilities to channelize them through popular media or through community level workers. It would be unfortunate if IEH in the Region is perceived as being just this and its wider applications in the movement

for HFA/2000 are lost. Community participation is another weak area. The latter is understood differently in different countries. Most governments view it as involving local communities in the health care delivery system, by training community leaders and volunteers at grassroot levels and forming village councils. Some see it as decentralization of administration and managerial processes at district levels. How many see it as a right and duty of people to participate in the HFA movement, in the planning, implementation and control of activities related to both their health and social development, in a movement towards self-reliance. There are no indications that this is how community participation is perceived.

There is no doubt that the single most important determining factor in inculcating a PHC culture in any country is the determined political will, idealism and commitment to the HFA goal. Another determinant, it can be stated, is a strong and pervading information-and-education-for-health programme directed at all levels of health care providers and consumers – politicians, bureaucrats, professionals, and the people.

Health cannot be imposed, it has to be attained, and without “the fullest cooperation of an informed and educated public willing to become involved and self reliant in matters of health”, this will be impossible. The time has come for a new kind of dialogue and action between health providers and the people. Information and education for health is the basic tool to begin this dialogue and lead to action. A free exchange of information between providers (be it health or any other related sector) and consumers must be regarded as the basic foundation for strategic planning, fixing priorities, identifying target groups and developing appropriate technologies on the one hand and, on the other, enabling communities not only to get actively involved in the health care process and delivery, but also to adopt healthy practices with dignity, pride and freedom.

The role of IEH must thus be understood and recognized in the context of:

- (a) developing a value for health. And health as an essential requisite for overall socio-economic development needs reinforcement, from time to time, at all levels. The importance of health for work, employment, education, success and happiness in life must be made known to all;

- (b) development of mechanisms for individuals and communities to express their views on the country's health policy and to take an active part in the planning and delivery of health programmes, including health education;
- (c) making decision-makers and health service providers understand the people's health cultures and values. Through constructive dialogue with communities, they must find culturally appropriate responses to health problems jointly with health workers and the community. The health service providers must know what people need and why, who to collaborate with and how in the provision of essential health care for achieving HFA/2000;
- (d) making people want to be healthy, know how to stay healthy, know when to seek help when needed and know what to do individually and collectively to promote and maintain health in partnership with the health services.

Formulation of IEH Policies and Strategies

IEH policies will necessarily be largely determined by national policies and priorities. To achieve HFA/2000, IEH will have to become an agent of social change. It will have to 'debureaucratize' health education, establish links with other sectors and community groups and take on an advocacy role focussing on policy makers, professionals, mass media and people. Informing and educating the population must form the intrinsic role of every health worker and for this training will be essential. IEH must become a principal tool for the health planning process itself. Decision makers must know where to concentrate their health efforts. They must be made aware of the problems experienced by communities in their contacts with the primary health care system and of the self-care practices at family levels. They must be made aware that there are times when individual health behaviour will change only when the social environment changes. IEH policies must be addressed to conflicts between vested interests and what is good for the people. A clear communications policy and legislation will be equally necessary for effective social communication.

Sales promotion of cigarettes is a case in point. Attempts to promote a non-smoking culture become futile against the heavy pressures imposed by

tobacco firms through advertising over mass media to encourage people to smoke. Even medical practitioners many of whom are engaged solely in curative services, may fall into the trap of vested interests of the drug manufacturing companies. All health professionals (especially those in the private sector) must be persuaded to understand that by promoting health they are not relinquishing their medical role but in fact gaining health responsibilities. IEH policies must promote inter-sectoral approaches and involvement of mass media, strengthen manpower development and training technologies and, most important of all, promote people's participation to make them feel that they not only have a right to health but that it is also their duty to attain it.

An IEH policy must recognize that to implement IEH strategy, IEH discipline must be seen as an equal partner with other disciplines in PHC and an adequate proportion of financial resources must be allotted to it; more than what is now available.

A fully developed IEH strategy must be directed to both policy makers and to the public to:

- create a heightened awareness of health both as a national and personal issue;
- lead to decisions;
- lead to behaviour change;
- lead to mobilization of all sectors of the government and society to participate in the Health for All movement, jointly and in partnership with each other.

The resource needs to adopt such a strategy must be recognized and identified, such as:

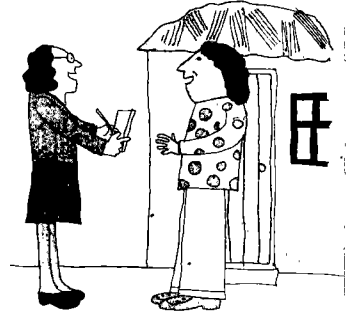
- experienced and skilled IEH specialists at all stages of IEH planning, implementation and research;
- national institutes and community-based organizations to be used to channelize IEH programme;
- use of appropriate communications materials, media and methods.

DECENTRALISED FUNCT

1. The movement starts with the people.



2. Do the felt needs truly reflect major issues?



Information an

The flow chart shows the planning process developing in the first row; implementation and evaluation of appropriate technology in the second row followed by increasing self-reliance, involvement and multisectoral coordination in the bottom row.

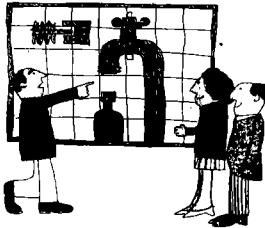
8. As progress is monitored, new needs emerge. The community is ready for the next stage.



7. How effective are the activities? What are the changes occurring?



9. The cycle for increased involvement and self-reliance develops at another level.

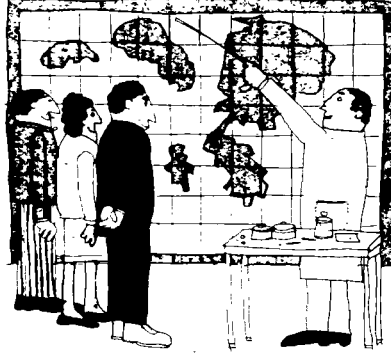
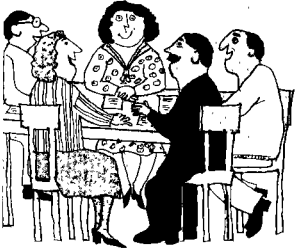


10. The community takes action to develop new resources.



CENTRALISED FUNCTIONS

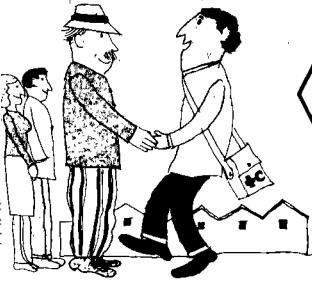
What are the priorities?
A dialogue is engaged with professionals.



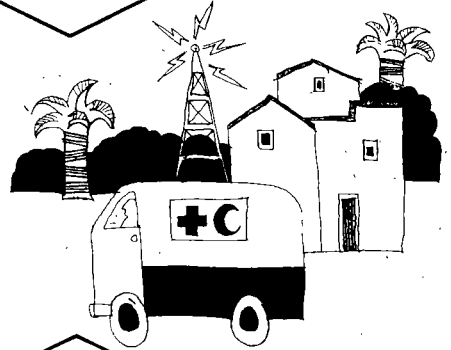
4. Central support comes into play. Plans are formalised.

education for health

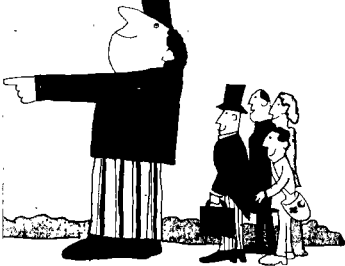
Action develops.
But is the technology appropriate?



5. Implementation starts.
Other sectors are involved.
Resources are coordinated.



1. Are programmes developing in the right direction?
Central and local activities are evaluated.



12. Greater involvement of all sectors helps fill gaps. Self-reliance becomes a reality.

And the cycle continues...

Strengthening of the IEH Organization

A relook into IEH – its meaning, purpose, policies and strategies – throws up the need to examine very carefully its organization within the country's PHC delivery system.

The existing IEH organizational structure in the countries of the Region must be assessed for its capability and capacity to integrate information and education for health and in this process to find out whether the IEH organization:

- (a) participates meaningfully and effectively in the planning of the PHC programmes of the country
- (b) is equipped to
 - plan strategies, manage, monitor and evaluate IEH programmes
 - produce and disseminate effective IEH material
 - meet training needs of all levels of personnel involved in IEH
 - conduct IEH research
- (c) has effective mechanisms established at all levels of administration, from centre to village, for inter-sectoral action and community participation
- (d) reaches the most peripheral areas of operation.

In strengthening the IEH organization for more effective IEH, policy makers will have to examine feasibilities for the following developments:

- (1) to involve chiefs of health education bureaus in the country's health planning process to provide to planners the information necessary for prioritization of problems and locations on the basis of feedback received from communities.
- (2) to establish statutory inter-sectoral coordinating bodies at central, provincial, district and sub-district levels that will meet frequently to chalk out detailed programmes on the basis of feedback received from communities. The sectors that are most closely associated with IEH are those of Public Information and Education, Women's Affairs, Social Welfare, Agriculture, Religion, Rural Development, Youth and the relevant NGOs working with developmental projects.

(3) to establish at community levels formal linkages between the various sector functionaries, e.g. community health workers, agriculture workers, teachers, rural and urban development workers, etc. and between these and the existing community organizations, formal and informal, that will establish continuous dialogue with the community. At present many of these functionaries operate in isolation unaware that it is only their integrated efforts that will bring about any change in the quality of lives of the people. Their contacts with the communities are also getting less personal since they often tend to identify themselves with government authorities who have time-bound tasks to perform, regardless of the community's readiness or willingness to accept such services. The development of the community level coordination is seen as crucial for effective IEH. Only when this is strong will the coordinating mechanisms at the upper levels be able to function realistically.

This "top-down bottom-up" approach needs more than just policy making and planning. It requires the strengthening of the IEH organization for effecting such an approach through:

- orientation, training and re-training programmes for policy makers and implementers at all levels of the organized structures and at community levels;
- balanced recruitment of appropriate staff representing health, behavioural sciences, communications and media and their management at the national and district levels;
- establishment of an evaluation mechanism that will provide effective feedback not merely to policy makers and planners but also to the implementers of programmes and to the people.

In addition to this, it is necessary to consider, specially:

strengthening of the research component of the IEH organization through establishment of research cells in the central health education bureaus and district units.

A health educator even at the most peripheral level must know how effective his/her work has been, what has been the experience of other workers involved in similar activities, their success stories and their failures. Only then can the workers' involvement be more complete.

All countries in the Region have organized health/medical research institutes. The IEH organization must establish and strengthen its links with such institutes, and must orient them to the need for health behaviour and other IEH research.

Decision-makers, on the other hand, must also be convinced for larger budget allotments for IEH research.

Some research is already going on in universities, often unknown to the IEH organization of the country.

A coordinating mechanism for IEH research that will involve all researchers from universities, especially medical and social science faculties, directorate of health services, health education agencies, media and from the institute of medical research must be established to assess current research, to give guidance in future researchable areas, to develop research tools to train, to conduct collaborative research programmes and to make research findings known as widely as possible.

Strengthening the Capacity for Production, Dissemination and Use of Relevant and Pre-tested IEH Materials and Equipment

Health education bureaus must periodically assess the needs for IEH material development, the topics to be covered and the quantities that are required. Producers must frequently interact with the communities for whom IEH materials are made to make them more appealing, acceptable and, in general, more communicative in a 'language' that is commonly understood. Before final production, the material must be pre-tested.

Through observation and informal channels of communication there is reason to believe that many of the IEH materials produced lie in depots underutilized due to insufficient dissemination and use. The logistics involved for dissemination have not been carefully considered at the planning stage. As many other agencies, both governmental and non-governmental, are also producing IEH materials, it is possible that there is a considerable duplication of materials that are produced in the different parts of the country leading to wastage of efforts and resources. Health education bureaus must build mechanisms to undertake inventories periodically of IEH materials in their countries. It is also likely that materials lie unused due to

irregular supplies or equipment not being in working order (particularly, projection equipment). What is often observed is that even when supplies are adequate, materials lie unused or are used inefficiently due to lack of training in users. Their maintenance and storage are other problems. Thus, material production by itself has little value, unless care is taken to effect its utilization.

Strengthening and Coordination of IEH Activities of Other PHC Programmes

In addition to health education and information programmes, some of the major programmes that operate in the countries of the Region are control of communicable diseases, EPI, MCH/FP, nutrition, prevention of blindness and other disabilities and in some countries also prevention of various non-communicable diseases.

In every PHC programme there is an in-built health education component. Apart from this, there are also special projects operating in the countries, funded from various sources, including WHO, which have an IEH content.

For example, in the UNDP-funded project "Intensification of action programme for PHC", which is being executed by SEARO, activities include strengthening communication, information and health education of communities to increase their motivation, involvement and participation. It also includes mobilization of women, NGOs and youth organizations for awareness and participation in the intensification programmes of EPI, control of diarrhoeal diseases and acute respiratory infections and provision of essential drugs.

At the regional level, an action plan for Women in Health and Development indicates that IEH elements will be strengthened in the several areas of improving nutritional status of women and children, prevention of drug abuse and other harmful addictions among women, prevention of communicable diseases, especially diarrhoeal diseases, and promotion of child care.

Making IEH Multisectoral

Since health, as WHO strongly reiterates, forms the nucleus of a country's socio-economic development, it is imperative that all sectors recognize its

strategic central position and find their own channels to strengthen it. IEH provides that ideal channel.

The Ministry of Education reaching out, as it does, both formally and informally to the most receptive groups in the population must be considered one of the principal actors in IEH delivery. In the South-East Asia Region of WHO, the positive correlation between literacy and health is more than apparent. Even among countries that otherwise share the same socio-economic and cultural characteristics, health statistical indicators, like IMR and CBR, are much more favourable where literacy levels are high, like in Sri Lanka and Thailand. This pattern is observed even within a country. In the State of Kerala in India which has a higher literacy rate than the rest of the country, infant mortality, crude death and crude birth rates are found to be much lower than the national averages. Life expectancies are also longer.

	<i>All India (1981)</i>	<i>Kerala (1981)</i>
Infant mortality rate (per 1000)	125.0	55.0
Crude death rate (per 1000)	14.5	7.5
Crude birth rate (per 1000)	33.3	26.4
Life expectancy	52.0 years	63.8 years
Literacy rate	36.1%	69.2%

There are reasons to believe that when efforts are made to promote female literacy, the health indicators show even further improvement. Studies from the south of India have shown that an educated woman acts more decisively in health matters, taking appropriate steps to promote nutrition, prevent illness and seek health care in times of illness.

Recognizing this, the child survival strategy of UNICEF now formally includes 3 Fs (food, family planning and female literacy) along with its GOBI (growth monitoring, oral rehydration, breast feeding and immunization) approach.

Apart from education, other sectors too must directly or indirectly be involved in health promotion.

Nearly all ministries concerned with the development sectors of their country's administration have their functionaries operating at various levels

of the governments' hierarchical structures, including the grassroot levels. For example, the Ministry of Food and Agriculture helps communities cultivate kitchen gardens, horticulture, etc. Poultry, livestock and fish breeding are further promoted by the departments concerned. Non-formal education for school dropouts and women are carried out by the Education Ministry. The Social Welfare Ministry has its own contacts with the people like the *anganwadi* worker of the extensive integrated child development service in India. Political parties have their outreaches too.

With such a large force functioning at the community level, ways to involve them as a critical mass for HFA leadership are not yet explored in the Region. The part IEH must play in this is obvious.

Media Support for IEH

To reach out to larger groups of people, IEH needs the support of the media sector. Recommendations pertaining to media support for the advocacy of HFA and PHC were made during the technical discussions on IEH held in 1987 in conjunction with the fortieth session of the Regional Committee for South-East Asia (document SEA/RC40/22). These were:

- (1) The health sector must develop a partnership with the departments of information and broadcasting so that communities have easy access to the right kind of information concerning their health situation and plan self-help programmes. This would help to counter any misinformation generated by the mass media.
- (2) Linkages should be established between various health-related sectors to get the maximum benefit of IEH programmes. Mechanisms should be developed for inter-sectoral coordination. Efforts should be made to involve fully NGOs, including women's and other groups, in IEH activities.
- (3) The possibility of adopting a multi-media approach and social marketing techniques using corporate resources might be explored.

Success Stories in Social Marketing of Health

An example of successful social marketing techniques has been demonstrated in Thailand in the promotion of family planning.

Like in many other countries, family planning in Thailand was considered a socially embarrassing topic, rarely to be discussed publicly. Until the seventies, the family planning programme was mainly "clinical" in its approach, but a change took place when a non-governmental agency, the Population and Development Association, launched a wide range of culturally adapted social marketing strategies, using carnivals, games, raffles, village fairs, weddings and other joyful occasions to spread the message of family planning. Virtually all possible communicable channels were creatively used. For example, troupes performed puppet plays, family planning messages were printed on T-Shirts, promotional material distributed at State dinners to emphasise its legitimacy, family planning catchwords were printed on pillow cases, business cards, etc. and face-to-face education was carried out by village distributors. In addition to all this, radio and television successfully reinforced the family planning messages.

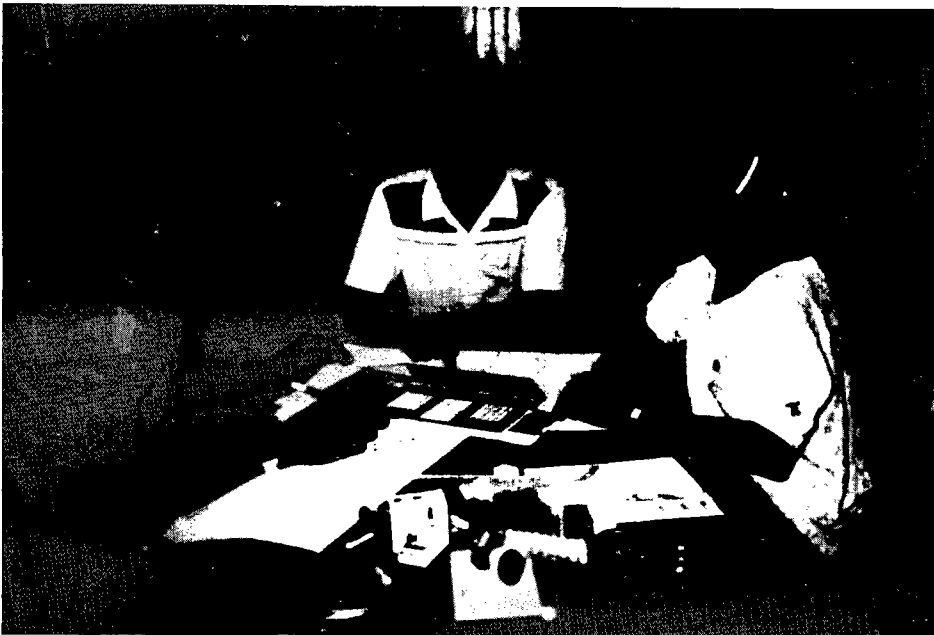
The Indonesian experiment is also interesting. A new weight chart for children was designed to reinforce the important message of monthly growth. In adopting the techniques of "social marketing", a design team which involved a communication specialist, an advertising agency, and a group of physicians and nutritionists, set up marketing goals to motivate mothers to seek monthly increase in the weight of their growing children. The goal was understandable, measurable and attainable. The weight chart became the prime communication tool with market appeal emphasizing on action leading to growth, and not just a clinical record of nutritional status. A variety of "product presentations" were field-tested among potential consumers leading to a "sales" approach. A catchy slogan, which meant "A healthy child grows in weight as he grows in age" advertised the new full colour weight chart and poster.

The photograph of the woman shown on the front, breast feeding her child, was selected with care – to represent an image of what the majority of women liked.

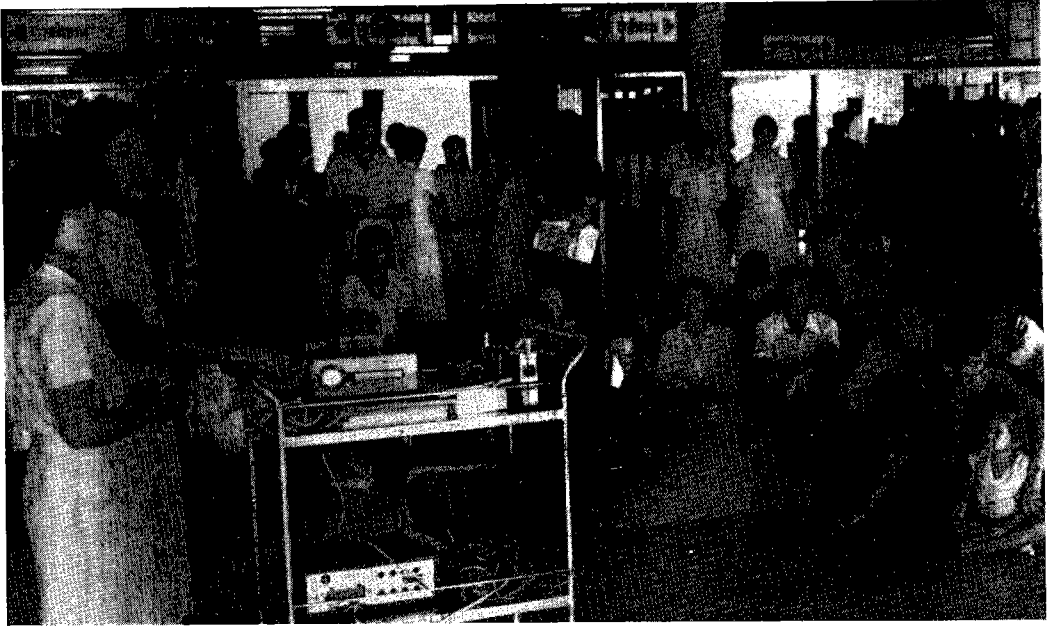
The nutrition experiment also demonstrated that education alone without the provision of food supplements – could improve the nutritional status of target groups. Carefully designed messages that were behaviour-specific, practical and applicable to the daily life of the rural Indonesian women were transmitted through various channels of communication, including village volunteer workers, the radio and posters. Evaluation showed



The school is an appropriate place to inculcate healthy habits in the young.



Development of IEH material needs careful designing for effective communications.



IEH through audio-visual communication is generally very appealing. It has special value in reaching out to illiterate and semiliterate groups.



Interactions between health providers and community members provide splendid opportunity for both groups to teach and learn from each other when chalking out strategies to tackle local health problems.

that the children in the target group had grown significantly more than other children. The food intake of children in the target group was also greater, reflecting the mother's ability to make better use of family food for feeding young children.

Effective Communication

IEH programmes are often ineffective, not because of lack of organizational structure or availability of communication materials or even dedicated personnel but because of an unimaginative communications strategy which has not taken into account the dynamic relationship between the communicator, the medium of communication (materials and channels) and the communicatee. The communication methods applied generally adhere to certain models developed over the years, for instance:

- the information 'model' is concerned only with transmitting information regardless of whether it is understood or acted upon,
- the instruction 'model' teaches health as if it were a syllabus, through classroom teaching methods, to captive target groups,
- the medico-public health 'model' is more concerned with placing accurate scientific facts before the people, based on modern medicine and technological advances, using complex messages through the formal health network channels.

These models must be discarded as they are essentially one-way communication channels which seldom influence behaviour change, rarely generate action for health and almost never involve the community.

In the design of an effective strategy for communication it is important that the planning process itself fosters true collaboration between the community and professionals in understanding and addressing health problems. This partnership is not always easy to achieve, but nevertheless must be sought. Analysing the target audience to develop a community profile could be the first step in this joint activity. Such a profile would reveal not merely audience knowledge, values and attitudes about various health problems but also the health behaviour. In addition, it would outline existing communication channels, and the key information sources in the community. It would identify activities in the community which are

appropriate for learning and knowing about the existing support groups where people discuss, make decisions and reinforce behaviour patterns. Community support and reinforcement is most important for behaviour change.

The community must also be involved in the identification and prioritization of needs. If the countries feel that their urgent problems are drug abuse and sexually transmitted diseases, these must be addressed first. It is likely that diarrhoea and malnutrition are also problems, though unperceived by the communities as pressing. When concerted efforts are made to deal with the felt needs first and the communities get convinced of their value, dealing with other problems becomes easier, especially when there is information support to convert unfelt needs to felt needs.

The next logical step would be to plan out the content of the IEH programme and its messages. The interaction between community and IEH personnel is particularly important at the message design stage. It is not uncommon to find that in unidirectional health communication there is a gap between the messages health workers wish to convey and the real information needs of the community.

For example, it would be pointless to push vitamin A concentrates if the community still believed that blindness was a manifestation of the wrath of gods, or to promote immunization where protective amulets are trusted. What the community would need is not aggressive propaganda to support the health worker's views, but convincing and credible information *backed up by appropriate services* that would enable them to shed off irrational beliefs and practices.

It is important that in the design of the messages there are no inconsistencies or double standards implied. This is more than possible as many health workers still perceive PHC as being a poor man's health system. What is appropriate for communities is not applicable to themselves. Home based ORS is sanctioned for poor communities but not for a health worker's child who will seek the more expensive pharmaceutical preparations when ill. *A common failing of IEH is the different approach propagated at home or at the health centre level and that carried out at the hospital level.*

The promotion of breast feeding is a common case in point. In hospital wards, many babies are still fed through the bottle, especially on the first day

of birth, while, at community levels, mothers are told that they must not discard the nourishing colostrum.

Immunization schedules also cause confusion. Private practitioners do not always follow schedules recommended by governments. In India, for example, the government EPI programme advises 3-dose schedules of Oral Polio Vaccine (OPV) while many private practitioners prefer to administer 5 doses. *Discrepancies and confusing messages lend little credibility to IEH.*

In designing appropriate messages it is also important to reinforce existing community beliefs which are positive to health. Communities do not always do the wrong things. There is sometimes a lot of native wisdom in what they practise, even if they do not understand its rationale. These must be reinforced. *In the design of the content of an IEH programme it is also necessary to identify the appropriate communication channels through which the messages will be communicated.* Here again one must learn from the community, as to which media will have the largest effective outreach, whether it is interpersonal, radio, TV, indigenous media, etc. or a mix of these. If women are the target audience then their capacities must be known, both in terms of time that they can spend and on their literacy of the medium. In the selection of an appropriate channel, it is important to consider whether it is cost-effective and whether it can be evaluated. For example, while mass media can fill a vital gap, they cannot easily provide for feedback and local sensitivity. *A participatory element in material production is also possible and often desirable* as the process itself is educational. When pictures are drawn by the community or scripts developed using the colloquialism that appeals, communication does become more effective. Talent in these areas must be sought. This is especially true when the indigenous media like puppetry, song and dance and drama are preferred.

It is important to *know what the existing support communication channels are within the community.* Are there organized events where the community gathers – women's clubs, radio listening groups, religious centres, the weekly markets, the community well, etc. – where communications normally taking place can also include health?

From the *Decade Watch* (Vol. 2, No. 4, 1983) published by UNDP in connection with the International Drinking Water Supply and Sanitation

Decade comes this interesting report: *Jochim talks, people listen* – “Jochim Chacha is much in demand in Rajasthan (India). When a handpump is to be installed; he settles disputes about location and payment. Appealing to people with local jokes and expressions, he gets across messages on the evils of money-lending and bureaucratic insensitivity. If higher castes are practising untouchability where handpumps have been installed, he is dispatched to settle the problem amicably.

Jochim Chacha is the name of a puppet who makes children go wide-eyed with awe. The creator of this puppet keeps his ears open to local gossip and disharmonies and then uses them in the puppets dialogues. This delights villagers, who are amazed that Chacha should be so aware of their problems. He weaves real personalities around themes that have a direct bearing on the villagers' everyday lives. Messages that would take months to absorb through radio and television – if absorbed at all – are conveyed through a puppet show in one evening. Shows have been given in over 100 villages. With donations of Rs. 10,000, people from other states are now being trained to follow this approach.”

After the message and the channel of communication have been designed and selected the next step in a communication strategy would be to pre-test the approach. This step is one that is most often overlooked in the planning of communication strategies.

Pre-testing in a representative segment of the community gives important inputs as to whether the messages are effective and appropriate, whether they need to be revised and if so, how. This is an important step to ensure cost-effectiveness of a programme.

The materials should be examined before their effective use, before their mass production. In this context, it is important to know how much has to be produced to avoid shortages and, as often happens, excesses. It must also be known whether the support needed for their use are available, like equipment, storage space and, most important of all, training for the users. Materials produced must be disseminated as widely as possible. For this, they must be durable and easy to carry and use. When the radio and TV are used to disseminate health information, the time scheduled for their transmission must be carefully considered. Many such programmes, addressed to women, do not reach the intended audiences because they are

broadcast during the periods women are busy completing their household chores. Again, however innocent the reason for this approach may be, consciously or otherwise, women are often made to feel guilty of their ignorance, stupidity and negligence about health matters. The harsh realities are ignored and these are that, in some countries of the Region, mothers are rarely the decision makers when it comes to taking responsibility for their own health and the health of their children. Their husbands and older family members decide what must be done. Therefore men also need exposure to IEH in maternal and child health, family planning, nutrition, etc. It is heartening to note that the WHO strategies with respect to the regional programme on Women in Health and Development includes "promotion and dissemination of information on health and population education aimed not only at women, but also at the male population". *Orientation and training for effective communication strategy* must be in-built in the planning of all IEH programmes. Policy makers will need orientation and training programmes will be necessary not only for health workers, media and other professionals, but also for community leaders, and other community level workers.

Finally, it must be strongly reiterated that *IEH is not just messages, materials and media*. These are merely tools in IEH delivery. IEH, more importantly, involves an effective communication strategy that must be carefully planned and successfully implemented to lead to effective health action by all people.

Focus on Women

Women as Target Groups

There are innumerable reasons why IEH programmes in the countries of the Region must focus on women. To begin with IEH would reach a very large segment of the population, a total of about half a billion females who live in the eleven countries of the South-East Asia Region. The size of the population by itself is not as important as the other attributes of this large group that makes it so special for IEH. In most societies in the South-East Asia Region, it is the mother who is the first level health care agent. It is she who promotes and perpetuates self care practices in the family. Her in-built health knowledge and attitudes generated from long years of traditional practices and experience equips her suitably (or otherwise) to manage many

of the common household illnesses. She is both doctor and nurse in the family. She has to play these roles out of necessity. Even today, inaccessible health services, their high costs and their inappropriateness compel her to practise her art of healing at home and to use home remedies to cure illness. It is estimated that in the countries of this Region, 50% or more of cases do not reach health services. Besides this fact, it is again the woman who bears the brunt of illness when members of her family fall ill. The very concern of women directed towards the welfare of their children, their husbands and their other family members make them highly sensitive to health problems. Women realize that health has a value; it is linked to well being, work, education, employment and income.

Access on the part of women to information on health is thus a crucial determinant of family health.

According to a popular saying "educate a man and you educate an individual", but "educate a woman and you educate a whole community". It is true that a woman utilizes her knowledge more efficiently and widely in introducing a health culture, first in her own home and then through sharing and demonstration in her neighbourhood and beyond.

Women are also the largest health providers outside their homes, within the primary health care delivery infrastructure of countries in the Region. It is reported that in India over 75% of the paramedical workers are women and traditional birth attendants are the backbone of maternal and child health services in many countries of the Region.

There are other reasons why IEH programmes should focus on women, an important one being to improve their own health status. Even though few countries in the Region collect specific information on morbidity and mortality that would truly reflect the existing health status of women, there are clear indications that a woman's own health needs significant attention.

As the social standing of women in any society depends on their child bearing performance, a woman's reproductive system is put to test early in life, while she is still in her teens, and over the years the system gets exhausted through overwork. Maternal morbidity is still alarmingly high in many countries of the Region and anaemia is a persistent problem.

Although many of the IEH components of the MCH, family planning, EPI and nutrition programmes have been traditionally directed to women, experiences have shown that even in other programmes, such as water supply and sanitation, women have been very effective recipients of educational programmes.

IEH must therefore focus on women within their three roles: those of health protectors, health consumers and agents of social change.

Communications Strategy

IEH aimed at women is a two-way process. Women should not be mere receivers of an IEH programme; they must get involved in its design and communication strategies. In this connection the pivotal role of mass media must be recognized. IEH mass communications must take into account the low reading levels of women and use more appropriate media, like the audio visuals. Messages must be relevant in the special context of the country's economic, social and cultural environment. What would be a priority in one country may not be so in another, e.g. raising the social image of women. Women must participate actively in the design of educational programmes. It is said that results of even small efforts have made it apparent that movements aimed at self-expression achieve a tremendous success in the course of information sharing and communication by women. Women must be trained in media production. Similarly, professional media experts must be recruited and oriented specifically to deal with women's issues.

Entry Points for IEH

There can be several entry points for IEH in women's programmes. When the objective is to orient women to health and influence their behaviour, health facilities like maternal and child health clinics, family planning centres, feeding programmes and women's wards in hospitals are suitable entry points. However, the more extensive outlets like creches and pre-school education centres, where women come to leave and pick up their children, women's clubs meetings and all the other places where women gather and meet (bazaars, water collection depots, etc.) must also be explored. A trained female functionary who operates at grassroot levels and has ready and easy access to women in their homes is an ideal IEH channel.

Some of the larger areas that can be identified in the government sector of some of the countries in the Region are the Integrated Child Development Services in India, the Integrated Family Planning Package in Indonesia and the Technical Cooperation among Developing Villages (TCDV) programme in Thailand.

Promotion of Women's Development

When women are "bypassed by education and technological advances and isolated from the mainstream of community action, development is progressing at half stream".

IEH must, therefore, do more than just motivate women into health action. IEH must recognize and make known widely the various limiting factors that operate within the social system of the countries of the Region that obstruct and prevent the development of a woman's full potential in achieving HFA goals.

Except for DPR Korea, Mongolia and Maldives, where men and women enjoy equal literacy status, in all the countries of the Region, the female adult literacy rate is less than it is for males. In some countries, the inequalities are much more gross. Studies have shown that a mother's educational level is a key determinant of the child's health. It is not surprising therefore that in Nepal, India, Bhutan and Bangladesh where the female literacy rates are the lowest, infant mortality rates are also the highest.

Another major handicap to women's development in the Region has been their low social status within the community.

Most countries in the Region have sex segregated societies. Percentage of women in the labour force vary from 1.6% in Bangladesh to 45.7% in Thailand. Many of these are in low paid agricultural activities in the unorganized sector, deprived of maternity benefits and other welfare measures. There are some glaring examples of social ostracism in the male dominated countries of the Region resulting in higher female mortality and higher female malnutrition.

By and large women have low decision making powers. Because of this it is to be considered whether giving information on family planning, nutrition,

etc. only to women really helps when it is the man in the family who has the control over how many children to have or how much food to buy. IEH in its focus on women must, therefore, also recognize the prevailing factors that sometimes limit the powers of women to change. IEH then must be directed to men as well even in the traditionally women's areas of family planning, maternal and child health and nutrition.

Promotion of women's health is very much a WHO concern. Through a series of resolutions, the World Health Assembly has drawn attention to the fact that women's health must be protected and that the participation of women is ensured at all levels of the health sector. In the South-East Asia Region, activities for Women in Health and Development (WHD) have started, the objective being to elevate women's status and their role as providers, promoters and recipients of health care. The activities will promote dissemination of health and population education not merely to women, but also to men, on nutrition, communicable diseases, occupational health, maternal and child health, environmental sanitation and mental health. In the Regional Office, a multi-disciplinary advisory core group has been formed. The WRs will act as the national focal points for WHO in the Member Countries of the Region. Among the various activities planned by WHD is the production of a health education package for use by various media.

It is worthy to note that all countries in the Region have established formal groups to promote women's welfare, either within or outside their governments or both. In Indonesia, the Pembinaan Kesejahteraan Keluarga (PKK) or the Family Welfare Movement is a well known nation-wide movement in which women play the central role in implementing primary health care programmes at the grassroot levels of the integrated community health service posts. The non-formal educational programmes of PKK are directed towards combating illiteracy and include courses in primary health care, family planning, environmental care and knowledge in civics.

NGOs promoting women's development are also active in other countries like Bangladesh, India, Sri Lanka, Nepal and Thailand.

Collaboration with WHO national focal points, governments and NGOs must be explored and mechanisms instituted to set into action programmes to promote the common cause of women's development.

Health development of women in a country will ultimately depend on the country's priorities and its will to advance women's health development. At ministerial and upper levels, women's departments must provide proper orientation for more realistic policy plans to upgrade the status of women.

IEH would have a major role to play, not merely directed to communities, but also directed to the policy makers, to assist them in defining priority areas and allocating the necessary resources for women's development.

Training Needs.

If it is recognized that IEH is indeed a grand participatory exercise which involves all levels of society, in its planning and implementation, then training must be seen in a very wide perspective.

Training in IEH involves orientation and training in

- concept
- programme planning
- management
- monitoring and evaluation
- research
- production and use of teaching and learning materials and equipment
- communications strategies
- intersectoral cooperation
- involving communities
- encouraging self reliance
- HFA leadership.

A situational analysis of training in IEH in a country could become a good starting point to review the current training programmes in the context of the PHC strategies of the country and to revise and reorient programmes to strengthen national capacities for IEH implementation. This exercise could lead to questions like:

Who Needs Training or Further Training?

This will, to a great extent, depend on the manpower development plans of the country especially within the health infrastructure. But not always so,

as with increasing community participation in PHC, needs will arise to train a substantial force of informal leaders in the community, people who are close to people, who share the same socio-economic-cultural milieu and who understand and use the same language for communication. Trainees for IEH would necessarily represent all levels in the country, from policy makers to people.

Who will Train and Where ?

The trainers too will have to come from different disciplines. Apart from the health education specialists and members of the health profession, behavioural scientists and media and communication experts would also need to form part of the training team. Often training will have to be multi-disciplinary and integrated. Only when training is integrated, will integration, in practice, take place.

In almost every country of the Region, there are facilities to train health education specialists at certificate, diploma, masters and now even doctorate levels in health education. Besides this, the training curricula of all doctors, nurses and other health workers have a health education component. Some form of training at health centre and community levels is also taking place.

In a number of countries, pre-service and in-service training programmes are available, but generally, there is no well planned and sustained continuing education programme that would periodically update workers with information and skills.

What Will Be the Content and Method of Training?

Training content and its duration will vary according to who is being trained and why, and whether they are health professionals, social scientists, paramedical workers, professional trainers, media people, men and women from the other sectors, school and college teachers, religious leaders, community leaders or other primary health care workers.

The very nature of IEH, based as it is on health behaviour and practice at home, family and community levels, demands that training be largely practical and field based to fit into PHC approaches, to reorient health education concepts for integrating information and education for health. IEH skills must be imparted; not merely communication skills, but also skills

in planning, rearrangement and evaluation and skills in using qualitative social research methods. The training in IEH must necessarily not only confine itself to the cognitive domains of learning, but equally to the attitudinal level.

For example, a primary health care worker in India cannot participate effectively in the family planning programme of the country if he or she maintains a preference for sons in the planning of a family or disregards the need for enhancing female literacy. 'Teaching' attitudes is not easy. Attitudes have to be learned, often through special processes using appropriate psycho-social methodologies.

The methods of training must itself reflect the communication skills of the trainer, using both conventional and non-conventional methods. Among the latter, role play is being increasingly used as an effective teaching/learning method. Liberal use of audio-visuals and other IEH information materials must be encouraged.

One of the main constraints in the use of audio-visuals both in training and in communication in the Region is the lack of electricity and other facilities in villages, necessary for purposes of projection. This however need not serve as a serious deterrent. Battery operated portable projection equipment is now being manufactured in some countries. Besides, effective posters, flip charts, pictures, flannel boards, games and other material serve as effective aids. Development of training modules for all levels of health and health related professionals, functionaries and informal community leaders would also greatly benefit both the trainers and the trainees.

At the community levels, training must necessarily be heavily weighted for communication skills that will motivate action. The five different levels for initiating health action are

- health worker's level
- individual level
- family level
- community level
- mass media level

The fortieth session of the Regional Committee for South-East Asia held in 1987 recommended that :

“The existing academic and in-service training programmes for health professionals should be reviewed, based upon Health for All strategies and its implied value, and strengthened in respect of information, education and communication sciences. The teaching should be participatory and field oriented. Similarly, the training of media personnel should include health orientation with close interaction between media specialists and contents specialists. Health workers at the grassroots levels must be equipped with skills to use appropriate IEH technology, involve individuals, families and communities to identify their felt needs, participate in their own health affairs for self-reliance and promote a healthy life-style.”

Promotion of IEH Research

As mentioned earlier one of the weakest components of the IEH programme in the countries of WHO/SEAR has been the development of IEH research. Yet its vital role in the planning, implementation and evaluation of IEH programmes is unquestionable. Research alone will reveal whether the existing IEH system is making any impact at all for attaining the goal of HFA/2000, whether the target groups identified and the problems addressed are appropriate, whether materials, media and methods are effective and whether the populations in need are covered. Research will reveal why people participate or don't participate in health programmes, what are the real factors responsible for unhealthy practices and what can bring about a change in the life styles of the people.

IEH research involves a number of researchable areas – self care practices, communication strategies, the effectiveness of materials, media and methods for communications, equipment research, research into IEH strategies and health behaviour research.

The following thirteen researchable areas in IEH have been suggested by WHO in support of PHC.

(1) Advocacy for Health

Each country in the South-East Asia Region of WHO has its own unique approach to achieve HFA/2000. WHO has played a significant advocacy role in the Region and has used IEH for directing the attention of the political leadership of countries to the need for primary health care, lobbying for

preferential allocation of resources, for health legislation and for reorientation and restructuring of health systems to support primary health care programmes. What is needed now is research into this process of advocacy for primary health care.

The following areas have been identified for study:

- (a) National policies and political philosophies influencing health of the people and how these policies and philosophies are translated into action.
- (b) The extent to which HFA and PHC messages have been absorbed and utilized and what more needs to be done to make them more effective.
- (c) How potent a force is religion in its role for advocacy for health ?
- (d) What is needed to improve the health literacy of populations.

(2) *Life-style*

For over two decades now attempts are being made through IEH to modify health behaviour of people towards achieving better health through healthy living. There is constantly a need to develop newer techniques in this direction through multidisciplinary research incorporating both health and the behavioural sciences. Some of the research areas identified are :

- (a) investigation of factors affecting the choice of life-styles and their uneven influence on different groups in the society,
- (b) what constitutes positive health behaviour and how individuals can be enabled to take greater responsibility for their own health and that of others, and
- (c) what are the change factors, methods and approaches for changing life-styles.

(3) *Self-care and Self-help Groups*

In most countries of the South-East Asia Region of WHO, fifty per cent or more of those ill never reach the health services. Illnesses are treated through self care based on home remedies and other self management practices carried out by individuals, families, neighbours, etc. There is a need to initiate research studies on the following:

- (a) identification of information channels to promote self-care in health, and
- (b) what is the communication network within the existing social institutions that strengthen the activities of self-help groups in solving health problems.

(4) *School Health Education*

The use of IEH to enable school children to participate in the HFA movement is being increasingly recognized in the Region. Research studies are needed to :

- (a) determine the extent of participation of schools in primary health care activities.
- (b) determine how out-of-school youth can be reached through IEH channels.

(5) *Interaction between the Community and the Health System*

It is now well recognized that for PHC to succeed a dynamic relationship between the community and the health care system must be established. Research studies are needed to know:

- (a) the extent of community commitment and the efforts made by the health system to involve communities in the decision-making process for health development;
- (b) the ways and means used by local communities to exercise social control in the management of PHC; how it operates and to what extent it is effective;
- (c) to what extent expectations and the responses of the community and of field workers are taken into consideration in health planning and management;
- (d) the community's image of health services and confidence in health workers and the factors influencing that image and confidence;
- (e) to what degree are the health services utilized and what factors determine their utilization, and
- (f) what are the characteristics of the health system that influence the relationship between the health system and the community at large.

(6) Community Involvement

There are various factors that influence a community's involvement in primary health care programmes. Research is needed to find out:

- (a) what are the socio-cultural factors, superstitions and other religious beliefs and the status of women that affect primary health care practices;
- (b) what factors influence decision making in adopting changing life-styles especially with respect to nutrition practices, contraception and non-smoking habits;
- (c) how does media influence decision making.

(7) Training of Community Health Workers

As community health workers form the first contact health care level in the formal structures of the primary health care organizations of the countries in the Region, it is important that their training equips them to adopt people-centred approaches in problem-solving for communities. What needs to be studied are:

- (a) training of community health workers in understanding community behaviour and in communication skills, the community approach, team work and inter-personal relationship, and
- (b) health workers' perception of their role in enlisting community support and participation, the way in which they work with communities and its influence on community response.

(8) HFA Leadership

To propagate the HFA movement it is important to develop a critical mass of people that will take up HFA leadership. It would be useful to know:

- (a) who could take up leadership at the national and middle levels, in addition to the personnel from the ministries of health.
- (b) what are the inter-personal communication networks in villages, districts, industrial establishments, etc. through which messages flow.

(9) Information Acquisition and Processing Behaviour

For modifying health behaviour, changing life-styles and achieving self-reliance, a level of knowledge is necessary to equip the individual and communities to control their health problems. When health information is given to generate this knowledge, it is important to know:

- (a) how the audiences receive the information given;
- (b) how information is processed within the psycho-social back grounds of the receivers.

(10) Need-based Problem-oriented Research

Many of the PHC programmes have problem-specific researchable areas like infant feeding practices, food safety, accident prevention, diarrhoea prevention and so on. It is important to know what are the behavioural aspects of specific health problems and how people respond to specific health interventions.

(11) Messages, Media, Channel and Audience

It is well known that often many health messages are not understood by the receivers. It is important to know:

- (a) media preference of communities;
- (b) effectiveness of communication channels; and
- (c) impact of audio-visual and other aids.

(12) Role of Mass Media

As mass media channels are being increasingly used in the Region, it is useful to:

- (a) know the relative effectiveness of the various types of media and methods used to promote HFA/2000, including the folk media;
- (b) test the combination of traditional and electronic communication techniques to promote PHC.

(13) *Intersectoral Coordination*

One of prerequisites for intersectoral coordination is a free flow of information. Studies could be undertaken to find out:

- (a) to what extent primary health care can be integrated with other health-related departments in achieving the goals of HFA/2000,
- (b) what are the barriers between various health-related sectors,
- (c) what are the linkages that contribute in maximizing the communication between health-related departments,
- (d) what are the appropriate methods to analyze inter-sectoral mechanisms of coordination between various organizations, and
- (e) what are the policies and social processes affecting the distribution of resources and participation.

The value of research ultimately depends on how well it is utilized for better IEH programme implementation. Unfortunately, this is limited. Research is still isolated from policies and programmes. Linkage systems between policy makers, administrators and researchers are weak and there is a lack of institutional, financial and human resources to synthesize and distribute research findings.

Ideally, a research programme must precede or at least accompany a major new activity. Methodologies also need careful scrutiny. There is need to revise existing KAP methods and complement them with participant observation methods and more participatory approaches. Health behaviour research must be augmented.

Health Behaviour Research

Health behaviour research (HBR) is seen as being concerned with "finding out what people know, believe, think and feel about health and how such cognitive and effective bases are related to what they do".

HBR in the Region must expand from the conventional KAP studies to look into the origin and causes of human behaviour, social values of people and how people interact with their environment and to provide decision makers with tools which will help them predict and influence human behaviour towards participatory health development. There are several health

behaviour researchable areas that fit into the priorities of the Region. These are :

- Self care practices
- Maternal and Child Health and Family Planning
- Nutrition
- Malaria
- Water supply and sanitation
- Leprosy
- Dengue haemorrhagic fever
- Community participation
- Health education
- Traditional medicine
- Non-communicable diseases

HBR is a joint effort between health scientists and behavioural scientists and to be truly participatory must involve the communities too in the design, implementation, dissemination and utilization of research.

The statistical survey method as used in epidemiological and sociological studies and the observation field method derived from cultural anthropology are other methods that are recognized in HBR.

Health professionals involved in HBR must move away from the 'biomedical' research models to the behavioural science research models, to solicit information on actual observed behaviour rather than mere verbal response, to arrive at causative explanation and not just correlation. Such research must throw up new models which will reflect on the processes of how a mother accepts ORS or gets her child immunized, how families start using latrines, how food distribution patterns within the family change in favour of women or how communities participate in the national health programmes of the country. There will also be need to involve social scientists in the HBR team.

Thus training in behavioural science research is urgently needed for all health professionals who will be involved in HBR and IEH Research. The Regional Office recognizes the need to encourage and support behavioural and social scientists and health educators in IEH research.

Research by itself is of little value unless its findings are known and applied by planners and those implementing IEH programmes.

The fortieth session of the Regional Committee in 1987 recommended that "Research in IEH should aim at developing/improving policies, strategies and methods of planning, management and evaluation of IEH programmes. It must be culture-specific, people-oriented and should result in community involvement in its own health care system. Results of such research must be made available to the training institutes, programme officers and health workers to be utilized in programme implementation.

Comparative effectiveness of various methods such as person-to-person communication, community organization and traditional and modern media might be tested in respect of health issues."

In short, improvements in promotion of IEH research, strengthening research capabilities and utilization of research results are needed. These include:

- (1) simplification of administrative procedures,
- (2) improving the research capabilities of IEH personnel including behavioural scientists,
- (3) bridging the gap between researchers, administrators and funding agencies,
- (4) encouraging researchers,
- (5) establishing/strengthening research units in health education bureaus,
- (6) providing technical support to use appropriate research methods in IEH, and
- (7) utilization of IEH-related research findings for PHC programmes.

Monitoring and Evaluation of IEH Programmes

Monitoring and evaluation processes are yet to develop in the health education and IEH programmes in the Region. This is unfortunate as IEH programmes often involve substantial budgets and in the final analysis it is important to know how all the money had been spent. This is specially so for the countries in the Region which have limited financial resources. A beginning can be made by convening a group of evaluation and communication experts to design a cost-effective strategy for implementation of IEH at country level.

Monitoring and evaluation of IEH is also important for other reasons. It provides the feedback that is necessary for more effective planning, setting targets, adopting more effective communication strategies and developing better training programmes.

The other broad areas for monitoring and evaluation are:

- (a) effectiveness of the programme in information exchange; and
- (b) effectiveness of the programme in terms of behaviour change and public health status.

These would also invariably have to measure the level of community involvement.

None of this is easy, but models will have to be developed at country level in course of time. Special efforts must also be made to include monitoring and evaluation in IEH planning, and to provide suitable training at every available opportunity.

The monitoring and evaluation models will have to be **country-specific**. Research activities must expand from the older standard evaluation exercises like pre- and post-intervention KAP studies to provide other data on social, economic and cultural factors underlying behaviour, on the accuracy of information presented, on its acceptability to decision makers and implementers and on the numbers of people reached.

Meanwhile, maximizing the use of existing opportunities to monitor and evaluate must be considered such as :

- (a) using the data provided by the existing recording and reporting systems and channels;
- (b) taking an inventory and assessing on-going research studies for their use in the evaluation process; and
- (c) integrating it with monitoring, audits and evaluations of other PHC programmes which have IEH components.

Collaboration with Non-Governmental Organizations and Other Agencies

In most of the countries of the Region, NGOs and international agencies, in addition to WHO, also provide and support IEH activities. The value of such NGOs lies in their ties with the local communities and their composition which often also includes the very poor.

They have a wider outreach, are willing to experiment and innovate, are developmental in their outlook and due to the very nature of the commitment that has drawn them to such work show greater concern for the welfare of the masses. Although the partnership between government and non-government programmes is getting stronger everyday, it is still not fully established, and resources of NGOs are not being fully harnessed to produce a complementary and synergistic impact. IEH is an integral component of many projects of such NGOs. For instance, the Bangladesh Rural Advancement Committee, a non-governmental organization, uses education as an intervention for diarrhoea management through village committees, home teaching and mass media. Concurrent evaluation has shown that people's participation has helped push the programme to make the home based ORT acceptable to the people.

The Voluntary Health Association of India (VHAI) is an important agency involved in IEH production and dissemination. It also serves as a resource centre for various kinds of IEH material produced in India and elsewhere.

Teaching Aids at Low Cost (TALC) and the child-to-child activity sheets produced by the Institute of Child Health, London, also provide useful IEH materials relevant to the South-East Asian context.

An International Council of Adult Education (ICAE), established in 1973, has also responded to the call of education to advance PHC. IC AE works to promote the process of learning and collective action for adults, towards responsible, human centred, social, cultural and economic development and, in late 1981, launched a study on the "Role of Adult Education in Community Involvement in PHC".

The South-East Asia Regional Bureau (SEARB) of the International Union of Health Education established in India in 1982, through consultancies, production of IEH materials, conferences, training, research



Community participation in water and sanitation schemes and other primary health care programmes become more meaningful with IEH.



The traditional forms of communications like puppetry are appealing especially in rural areas and can effectively be used to communicate health messages.

and publication of a quarterly bulletin, also helps to advance the interest of health education in the Region.

Besides these, there are several other organizations involved, either directly or indirectly, with health development. They generate useful IEH material, particularly in the little known areas of community participation and inter-sectoral approaches. Like for example, in the Sarvodaya Shramadana movement of Sri Lanka which is an integrated programme of village re-awakening. Here the initiative for taking responsibility of the village self-development programme is taken by the village leaders themselves. The experiences gained in using such innovative approaches would serve as excellent IEH resources both for policy-makers, trainers and the community.

Collaboration with UN and Other International Agencies

With the realization that health is an essential part of overall socio-economic development, several UN and other agencies, apart from WHO, support various aspects of health development.

Productive collaborations in IEH could well be effected with:

UNICEF which is already very active in the field of health communications which support the GOBI strategy.

UNFPA concerned with MCH and Family Planning.

FAO collaborating with WHO in the field of vitamin A deficiency induced diseases.

WFP which has special programmes for expectant and nursing mothers and school children.

ILO which is concerned with occupational health and safety.

ESCAP in the area of health literature, information and support through linkages of the HELLIS network, the health services research information network and the PHC information network.

Support from various bilateral agencies involved in health development work could also be sought, for example, from :

NORAD involved in contraceptive surveillance and immunization programmes

DANIDA involved in drug action and leprosy programmes

SIDA involved in malaria, tuberculosis and leprosy

and many others engaged in health related development activities in the WHO South-East Asia Region.

Finally, as IEH pervades the activity of all PHC programmes, support for development of IEH approaches and materials, within approved PHC projects, must be sought at every opportunity.

Establishment of an IEH Resource Centre

In every country of the South-East Asia Region of WHO there are already existing, in varying degrees, significant amounts of IEH materials either produced in the country or acquired from external sources, like books, reports and other such documents, pamphlets, leaflets, brochures, visual materials, like posters, photographs and flash cards, audio visual material like slides, overhead transparencies, audio tapes, films and video tapes. Various other teaching and learning aids like games, puppets, role-play exercises, etc. are also available.

Such material lie with ministries and with different health and health related development agencies operating in the country. As co-ordination between agencies is not always existing at the desired levels necessary for exchange of materials or even exchange of information, their accessibility is generally poor. There is, thus, an ineffective use of such materials. Such a situation also leads to unnecessary duplication of efforts in production of new materials. For example, it is not uncommon to find vast quantities of IEH material relating to a topic like immunization, while there may be little or nothing available to promote perinatal care, essential drugs or mental health.

To avoid duplication of efforts, to provide direction on what needs to be further developed and, most important of all, to provide information to all those interested in and involved with IEH activities for effective utilization of available material, it would be worthwhile for the countries to undertake an exercise to identify first all existing IEH materials available in the country, then collect this material, catalogue them and publish a directory of IEH materials. To make the directory more useful, suitable annotations to each

entry may be provided that will list the source of material and describe its purpose, its contents and identify its potential users and target audiences. The directory with suitable updates from time to time could serve as an effective and much needed information service to all users of IEH materials. The directory will serve as even better resource material for IEH if the experience of users of the materials, and their success and failures are included in the annotations.

Publishing a directory of IEH materials is only the first step towards the development of a more active measure to disseminate IEH information through forming, at the next stage, a Resource Centre. The functions of a resource centre would be to :

- (1) collect all IEH materials available;
- (2) publish and distribute the Directory of IEH materials to both governmental and non-governmental organizations;
- (3) update the information contained in the Directory from time to time;
- (4) modify the existing IEH materials to suit the local language and cultural requirements of target groups within the country;
- (5) loan IEH materials to users at nominal rates;
- (6) help users select appropriate IEH materials;
- (7) duplicate selected materials for wider dissemination and use; and
- (8) develop further IEH materials.

*Collaboration in Activities Planned during the
Fortieth Anniversary of WHO*

The fortieth anniversary of WHO in 1988 will provide to countries an unique opportunity for health promotion through IEH.

A detailed workplan drawn up by the Regional Office was endorsed by Member Countries at the fortieth session of the WHO Regional Committee for South-East Asia held in 1987. The plan incorporates collaborative activities through interaction between the WHO Representatives and national counterparts for planning and celebrating the fortieth anniversary not just on World Health Day, but throughout the year, highlighting the health development activities taking place in the countries of the Region. For this

purpose, a focal point has been identified in each country that will assign responsibilities to various organizations, involve NGOs, produce and distribute appropriate information materials, organize seminars and workshops and carry out health related activities.

Country activities suggested by the Regional Office are :

- (a) soliciting messages from heads of states and other dignitaries and to release these through the mass media;
- (b) identification of a priority health programme in the country in the context of HFA/PHC and reinforce the credibility of WHO collaboration and the goal of HFA/2000;
- (c) collaboration with other UN agencies to highlight common objectives;
- (d) initiating steps with national postal authorities for issue of a commemorative stamp;
- (e) use of mass media both to promote healthy living and to highlight WHO's collaborative activities in the Region;
- (f) encouraging essay competitions, sports, exhibitions and other events in the country to promote a healthy life-style.

Throughout the year, medical and nursing colleges, health and health related ministries, NGOs, and social institutions, youth and women's groups will be encouraged to celebrate the anniversary.

The critical target groups for initiating such activities would be :

- (a) heads of states, governments, ministries of health, education and related ministries
- (b) parliamentarians, as individuals
- (c) community and mass organizations, trade unions, and youth organizations
- (d) professional organizations and NGOs
- (e) media, particularly radio and television
- (f) other UN agencies

While the WHO Representatives (WRs) could make a significant contribution by briefing key persons in the various ministries about WHO's work and

activities, nationals working in WHO supported programmes could also through their personal contacts and through mass media explain the achievements and success of WHO collaborative programmes in their countries.

Detailed activities are expected to be worked out at the country level between the WRs and the national focal points of the anniversary celebrations.

Many of the following activities, with appropriate modifications/additions, could also be considered at country level, in collaboration with the Regional Office:

- (1) Preparation of briefs on the World Health Day theme "Health for All – All for Health" and on each of the other 12 themes selected by the Regional Office for dissemination every month throughout 1988, for use by mass media. In the briefs for press and television an appropriate photograph could be included. The briefs could be supplemented with other information materials received from the Regional Office particularly the information kits.
- (2) Transmission of briefs to mass media for regular releases once a month. Periodic face-to-face meetings between WRs, national focal points and the mass media sector may be necessary to ensure an effective follow-up of this activity.
- (3) Screening of available audio-visual material on WHO in the Region on the national TV network or in cinema houses on World Health Day or on any other suitable day after giving prior information and publicity.
- (4) Translation and publication of the information booklet and information kits received from the Regional Office into local languages.
- (5) Supplementing the information kits with additional appropriate local specific information, if it is found necessary.
- (6) Despatch of all such materials to relevant organizations in the country, both governmental and non-governmental, including women and youth groups, schools, NGOs in development, etc.
- (7) Commissioning of articles on "success stories in PHC" and releasing these through the mass media in local languages.

(8) Preparation of suitable audio-visual programmes and exhibits to further disseminate the messages contained in the various themes selected by the Regional Office for 1988.

(9) Use of all such information material for screening and display at various national and international days or weeks observed in the countries, for example, World Health Day, International Women's Day, World Environment Day, Childrens' Day, Teachers' Day, Mothers' Day, Family Planning Day, No Smoking Day, Disability Day, etc.

It may be necessary to produce some additional material such as posters and slides, in collaboration with WRs, for such specific occasions.

(10) Use of all opportunities to display such material as also all WHO publications, particularly of the Region, at government offices and other places, at group educational activities and other such events, whenever the occasion arises.

(11) Encouragement of and support to competitions on the WHO themes selected for 1988, e.g. competitions in essay writing, photography, drawing, painting, performing arts, scripts for mass media and indigenous media, children's stories, advertisement copies, exhibits, etc.

(12) Concentrating these above efforts at community level, especially rural populations. This in itself will generate further IEH development in the country, through spotting talent and innovative approaches.

(13) Use of the existing movements in the country committed to education and development, like the People's Science Movement in India, to propagate IEH.

(14) Other promotional activities that could be undertaken are production and distribution of stickers for vehicles, stationery, etc., printing the anniversary messages on T-shirts and giving suitable awards to people and organizations who have been exemplary in IEH/PHC delivery or research.

3.2 Regional Perspectives

It is agreed by all that the ultimate responsibility of promoting IEH in the Region will rest with Member States and their governments through national

efforts to implement strategies and programmes to achieve social mobilization for health. The crucial role the WHO Regional Office will play to accelerate this process will centre on advocacy and collaboration.

Advocacy for Health for All and Primary Health Care

To fulfil its constitutional function as the co-ordinating authority on international health work and provide to countries a framework within which health can reach all people, advocacy for health will continue as an important function of WHO.

The movement of Health for All by the Year 2000 with Primary Health Care as the key approach initiated by WHO 10 years ago and advocated over the decade, has already received visibility in the countries of the Region. The Regional Office through strengthening its advocacy efforts both at national levels and the regional level, proposes to increase this visibility and strengthen its credibility by making it known to all that Health for All is attainable. The target group addressed will be policy makers, providers of health services and health service consumers. The political leadership of the countries must be convinced that "investment in health is sound economics, a political asset with popular appeal and a social imperative".

Advocacy efforts will be aimed to provide to the countries information and explanation of WHO policies and the PHC strategies to attain HFA/2000, the need to reorient and restructure national health systems, to develop appropriate technologies, to institute necessary legislations and to mobilize resources in support of PHC and of WHO's promotive, supportive and catalytic roles to realize these in the countries of the Region.

Advocacy is seen as a function of every staff member and the role that IEH will play in this is all but obvious.

IEH Commitment in the South-East Asia Region of WHO

The Information and Education for Health programme is receiving increasing importance as an essential element of PHC in the Region. The importance given to IEH is reflected in the resolution adopted at the thirty-ninth session of the Regional Committee in 1986 which decided to hold

technical discussions on IEH in support of HFA/2000, during its fortieth session in 1987. Again, at the thirteenth session of the South-East Asia Regional Advisory Committee on Health Research, held in 1987, it was reiterated that IEH is of fundamental importance for the HFA strategy and there is need for relevant research in this area. The Regional Committee at its meeting held in 1987 fully endorsed the various recommendations made to strengthen IEH in the Region.

The specific objectives of the IEH programme in the Region's medium-term plan for 1990-1995 are to foster public information and education for health in order to:

- (1) motivate people to be healthy, to know how to stay healthy, to seek help when needed and to do what they can individually and collectively to maintain and promote health in a dynamic interaction and partnership with health services; and
- (2) promote and sustain community involvement in PHC through the mechanism of information, education and community organization.

The targets by 1989 are that all the countries in the Region would have:

- (a) a national information and education set-up to act as a "permanent operational arm of the health-for-all strategy" by generating the necessary public support and community involvement;
- (b) developed or expanded public information and education for health as an integral part of the primary health care programme;
- (c) developed mass communication strategies, extended and expanded public information as an integral part of health education;
- (d) developed community-based and task-oriented training programmes for primary health care and other health-related workers in public information and education, including appropriate health education curricula, learning resource material and faculty for health training institutes;
- (e) extended or expanded health curricula for primary and secondary schools and teachers, colleges, trained teachers in health teaching, and where necessary, established post-graduate teacher training programmes in school health education; and

- (f) undertaken research on social and cultural determinants of adoption, change and community participation as a basis for decisions on appropriate information and education for health (IEH) activities.

The areas that will receive specific emphasis will include the integration of information and education in each component of the primary health care package for training of health workers, strengthening of the teaching of health education and communication sciences for health professionals and "Health Development" for media personnel for the advocacy of Health for All by the Year 2000.

Collaborative Activities with Member Countries in 1988-1989

The proposed regional programme budget for 1988-1989 supports IEH activities as a major thrust in several countries of the Region. "The major task of the programme would be to bring about effective coordination between the two components for concerted action to achieve the common goal of developing a well-informed and motivated community for effective implementation of the programme. While support will be provided to develop and improve information/education materials and methods appropriate for each country, efforts to utilize the IEH approach in each element of primary health care, strengthen content of IEH in the training of primary health care workers and primary and secondary school teachers and create a critical mass of community leaders having appropriate orientation towards health development, will be accelerated."

At the country level WHO will support activities in the three major areas of programme development, human resource development and research. These include:

- strengthening of national capabilities for advocacy for health,
- integration of IEH in the planning, implementation and evaluation of health care programmes,
- extending and expanding IEH services,
- integrating IEH in all the elements of PHC,
- introducing 'health development' in the curricula for the institutes of mass media and training programmes of media personnel,
- strengthening the teaching of health education and communication

sciences in the training of health education specialists and health and health related professionals and PHC workers in the context of HFA through PHC,

- upgrading training institutes that offer diplomas and **degrees** and doctorates in health education,
- creating a critical mass for HFA leadership,
- developing IEH resource material,
- strengthening of the health component of the curricula for teachers of primary and secondary schools, and
- strengthening capabilities of health professionals for research in behavioural sciences and health education.

In 1988-1989, technical and financial support for the IEH programme in the Region is proposed broadly for training, research, monitoring and evaluation, health education material production and communications, supplies and equipment. Besides these, many of the other programmes supported by WHO/SEAR are also proposed to have IEH components like nutrition, maternal and child health and family planning, control of communicable diseases, prevention of disabilities, etc. It is envisaged that there would also be a definite place for IEH in the other programmes like environmental health, mental health, alcohol and drug abuse, health of workers and in the control of non-communicable diseases.

Training Programmes

In the Health Manpower Development Programme of WHO for the South-East Asia Region, training has always received considerable emphasis. During the previous five years, SEARO held three intercountry workshops related to IEH:

- (1) Integration of Public Information and Education for Health, in 1983
- (2) Training of Media Personnel at the Professional Level for the Advocacy of HFA/2000, in 1986 and
- (3) Strengthening the Teaching of Health Education/Communication Sciences at the Professional Level in Support of PHC, in 1986.

Future training and orientation programmes for IEH development in the Region may have to be considered for the following:

- (1) Training in all aspects of IEH – planning, management, services and research for IEH personnel, especially training for further development of identified weak elements, such as participatory communication in health, monitoring and evaluation of IEH and IEH research.
- (2) Orientation in IEH for decision makers and key leaders in the community.
- (3) Introducing/strengthening IEH components in all other training and orientation programmes carried out by WHO in the areas of planning strategies, management and research of PHC systems and training programmes in MCH, EPI, Nutrition, Environmental Health, etc.
- (4) Promoting staff development in the Regional Office through the staff development committee.

If Advocacy for Health is considered one of the major responsibilities of WHO, then each WHO staff must be equipped to carry out this responsibility. IEH will be a major input for developing such a force to fit into the advocacy role.

Besides these, with the increasing interest in IEH in Member Countries and the keenness to develop IEH further, technical inputs from WHO to develop a high level of national expertise in IEH will be called for. While consultants can be recruited for this purpose, it will also be necessary to develop WHO staff to meet some of these needs and to provide further cohesive and effective support to countries in carrying out their strategies for Health for All.

Training for HFA Leadership

Under the Health for All Leadership Development Initiative launched by WHO in 1985, WHO held a series of workshops and seminars in various Member Countries of the Region in order to develop a critical mass of people capable of assuming leadership positions in health and health-related sectors to meet the challenges of HFA/2000. The role of IEH in this is implicit. A folder containing information material on HFA Leadership Development prepared by WHO Headquarters has been widely distributed by the Regional Office. Comprehensive modules for use in universities and

public health institutes to impart training in leadership qualities and principles of HFA are also being developed.

The Regional Committee for South-East Asia at its thirty-ninth session in 1986 reiterated its intent to build HFA leadership. IEH would accelerate this development through providing a clear understanding of the value system implicit in the strategy of HFA and its principles and strengthening their capacities to motivate others in attaining the HFA goal.

Establishment of a Regional Clearing House for IEH Information and Materials

During the technical discussions held on IEH in support of HFA/2000 at the Regional Committee session held in 1987, it was recommended that "WHO should examine the feasibility of setting up a clearing house mechanism to facilitate the exchange of IEH related information among the member states". This would indeed be a valuable service rendered by the Regional Office to the Member Countries.

A regional clearing house would serve as a centre for dissemination and exchange of IEH through:

- (1) collection and cataloguing of all relevant information on IEH from :
 - (a) reports and recommendations and resolutions of meetings, workshops, seminars and other group educational activities, directly or indirectly related to IEH,
 - (b) documentation of IEH projects,
 - (c) documentation of success stories,
 - (d) compilation of IEH materials produced in different countries, giving descriptions of their use,
 - (e) lists of IEH research and their findings
- (2) dissemination to WRs and national focal points this information at periodic intervals directly, and through the HFA Newsletter, and
- (3) dissemination to other agencies and individuals, on request.

Apart from meeting an important need, this service will also greatly enhance WHO's public image in the countries of the Region.

Monitoring and Evaluation

WHO has developed a number of indicators to evaluate the HFA strategies in the Member Countries. On the short list of indicators suggested for use is one on monitoring and evaluation of the country's health education policies. The indicators would measure the kind of mechanisms formed, strengthened and functions to involve people in the implementation of strategies, to enable people to express their perceived needs, to find out if representatives of political parties and organized groups, such as trade unions, women's organizations, farmers and other occupational groups, are actively involved and whether decision making on health matters is adequately decentralized to various administrative levels.

At the regional level, WHO will collaborate with the countries in monitoring their activities against IEH-related targets and in the perspective of HFA/2000.

The information needed for monitoring and evaluation will be acquired from materials available at country level and from country reports presented at meetings, seminars and workshops. Reports of consultants and reports of staff visits to countries will also be used. The increased focus of IEH programmes on country level technical cooperation activities, aimed at health workers and middle level managers, calls for the development of suitable input and output indicators. Indicators relating to programme activities will reveal whether or not these activities have increased national capacity to perform the special tasks of IEH. They will include assessment of the numbers of countries in the Region which have:

- (a) drawn up a national IEH policy and strategy to support the development of health infrastructures based on primary health care;
- (b) integrated IEH in national health planning;
- (c) integrated IEH activities in national health programmes;
- (d) involved IEH specialists in policy formulation, planning and evaluation of health, education, information and other sectors;
- (e) integrated an IEH component in the infrastructure and training institutions of health, education and information agencies at central, intermediate and peripheral levels;
- (f) made health and health-related information easily accessible to the community;

- (g) provided IEH training for personnel from the education, media and other sectors;
- (h) made effective use of new and traditional communication technology;
- (i) identified and organized inputs to IEH from various socio-economic sectors at national, provincial and community levels; and
- (j) strengthened applied social and behavioural research related to health promotion/protection, self-care, community involvement and use of available health services.

Output indicators would reflect what the people and communities know, believe, feel and do about maintaining health in addition to epidemiological indices, including morbidity and mortality.

While it is realized that impact evaluation in IEH is a long-term process and is difficult to measure, some attempts must be made to evaluate IEH impact also within the framework of carefully planned small-scale projects.

4. CONCLUSION

In conclusion, it can be stated that an overview of IEH development in the Region shows some very positive developments taking place in many of the countries of the Region. On the other hand, there is a need to fill some very wide gaps too.

It can confidently be stated that the seeds of change have begun to take root. The concept of IEH is 'catching on' in the Region. There is the beginning of a realization that to attain HFA, people need IEH. Media specialists are beginning to get involved, linkages between the health and information sectors are getting stronger, and there is a greater use of mass media channels to disseminate IEH. There is also an increasing realization that sectors other than health can and should get involved in producing an informed public who will participate in the movement of HFA/2000.

Services are being expanded to train larger groups in the community to deliver IEH, to make training multi-disciplinary, to augment training facilities and to improve the quality of training content, training methods and materials. Community level health functionaries and other key persons, like teachers, religious leaders, etc., are increasingly being involved in IEH delivery. But this is only the beginning. There is still a lot to "catch up" on. IEH is still not uncommonly seen by many in the Region as a discipline which is synonymous with health education. The health education structure in the countries of the Region is tight and narrow. Approaches are top-down with no, or very little, community participation.

There is no health education organization beyond district levels that will take responsibility for IEH. Policy makers and educationists could do with more orientation in IEH to convince them of the need to reorganize and strengthen the health education organization, to integrate information and education for health and to allocate larger resources for IEH.

Mechanisms for inter-sectoral collaboration are ill-defined and do not exist at the levels of the community. IEH strategies have hardly taken into account the need for participatory forms of communications. Production of IEH materials is still highly centralized.

Monitoring and evaluation of programmes is weak and there is very little research going on in IEH. The multi-disciplinary teams responsible for IEH delivery rarely include significant representation from the behavioural sciences. There is also a greater need for improving all components of training.

The future perspective for IEH at country levels is based on the assumption that there is, in the countries of the Region, a political will to achieve HFA/2000.

To fit into the future perspective, countries may feel the need to look into their existing IEH strategies and programmes and to implement newer approaches to make IEH more effective and purposeful.

To sum up, some of the logical steps that could be taken to assist this process would be :

- (1) to know the existing health status in the country and to identify the prevalent health problems;
- (2) to select from these the major areas that have the widest implication for HFA/2000;
- (3) to provide appropriate services to meet the major health needs;
- (4) to understand the pivotal role of IEH in providing such services to motivate people to
 - participate in the attainment of health
 - utilize effectively the services provided
 - adopt a healthy life-style;
- (5) to adopt effective communication strategies to take IEH to all levels of the society; and
- (6) to research into, monitor and evaluate IEH programmes.

All this may need strengthening and augmentation of existing resources such as:

- (1) finances – wider sources may have to be tapped from bilateral and multilateral agencies
- (2) strengthening of the organizational structure of health education to incorporate IEH, specially in the areas of

- inter-sectoral activities
 - community participation
- (3) wider and more effective use of public information channels and mass media
 - (4) improving, both the quantity and quality of various categories of manpower responsible for IEH planning and implementation through
 - suitable recruitments
 - strengthening of existing orientation and training programmes (including training materials) at all levels, especially for
 - (a) planning, organization, management, monitoring and evaluation,
 - (b) eliciting community participation leading to self-reliance,
 - (c) adopting effective communication strategies,
 - (d) research, and
 - (e) strengthening of academic and training institutes particularly those of health and media to incorporate the newer approaches to IEH in terms of staff development, revision in training curricula and training methods and production of training materials
 - (5) augmenting supplies of IEH materials and equipment and ensuring their effective use.

Countries may also consider the establishment of IEH resource centres that would identify, collate and compile all relevant information and materials available on IEH in the country to facilitate:

- (1) identification of further needs in IEH development,
- (2) IEH research, and
- (3) exchange of information and materials within the country and within the Region.

WHO has played a vital catalytic role in the development of IEH in the countries of the Region. It has also given direction and support in developing concepts and policies, in strengthening IEH organization and training and in production of IEH material. It has, in many ways, in partnership with its Member Countries, provided a strategy for IEH take-off. With increasing 'advocacy for health' programmes by WHO, with the scaling up of IEH operations in the fortieth anniversary year of WHO, with the upsurge of new approaches in information technology and with the communication

revolution that is sweeping the world today, it is certain that, given the political will, IEH will accelerate the march of the countries of the WHO's South-East Asia Region to reach its goal of HFA/2000.

A close liaison will be necessary between the national focal point (NFP) for IEH and the WR in the country. The WR will translate IEH objectives in the Region and provide suitable assistance for catalytic activities in the country. The WR would also provide to the countries IEH materials to disseminate during the fortieth anniversary year of WHO. It is hoped that, in the very near future, a network of IEH NFPs of different countries in the Region would develop to make IEH, in support of HFA/2000, a vibrant and pulsating programme in the South-East Asia Region.

5. ANNEXURES

BANGLADESH

Background Information

The People's Republic of Bangladesh is one of the "least developed countries." In 1980, it was estimated that 80% of the population lived below the poverty line. Bangladesh is the third most populous country of the Region, with a population of 98 million (1984), a growth rate of 2.4% (1985) and a population density of 700 per sq. km. Only 15% of its population is urban (1984). Demographically, the population is young with 46.7% under 15 years of age (1984). Bangladesh has a male:female sex ratio of 107.7:106 (1981). The adult literacy rate in 1981 was estimated to be 39.7% for males and 18.8% for females. Life expectancy at birth was 50 years in 1984.

Health Situation

About 45% (1984) of the population in Bangladesh are covered by health care. Malnutrition, infectious diseases and rapid population growth are major problems confronting the country. The infant mortality rate is 128 (1984). About 50% of newborns have low birth weights. More than 50% of infant deaths take place in the neonatal period, the major cause of death being tetanus. In children between 1 and 5 years, diarrhoeal and respiratory infections take a heavy toll. Florid forms of classical kwashiorkor and severe marasmus are still seen. Available evidence indicates that about 28% of younger children in rural areas suffer from moderate to severe forms of malnutrition and this condition seems to have deteriorated since mid-1970s. Iron deficiency anaemia is widely prevalent both in women and children. Nearly 5% of rural children suffer from xerophthalmia and about 11 million people suffer from goitre. About 43% of the rural population have access to safe water, but a mere 2% have adequate facilities for waste disposal. Diarrhoeal diseases are very common. Other communicable diseases, like malaria, tuberculosis, and leprosy continue to afflict the population.

IEH Development

Health education is considered as a major component of PHC in Bangladesh. However, budgets allotted to health education constitute only 0.13% of the total health budget.

The Bureau of Health Education under the Directorate General of Health Services is the central organization which plans, produces health education materials and provides communication support and training to primary health care activities, school and hospital health education. At each of the divisional and district levels, there are health education units which are supported by the central bureau. Manning the bureau and units are trained health education officers involved in planning, management and implementation of the health education programme at national, divisional and district levels. Health education, however, is not the prerogative of such officers only. Health education is considered as a responsibility of every health worker in the delivery of PHC. Health education is thus integrated into the training programmes of all categories of health and health related personnel and in the school curricula. Training programmes are also held for agriculture extension workers, physical training instructors, school teachers, community leaders, religious leaders and health personnel of non-governmental organizations. The Bureau of Health Education offers a three-month certificate course in health education, and the National Institute of Preventive and Social Medicine offers programmes for master's degree in health education.

Health education efforts in Bangladesh have been largely directed towards the control of water-borne diseases, oral rehydration therapy, water purification and construction of waterseal latrines and improving immunization coverages. Efforts are also made towards control of malnutrition, through mobilization of communities to develop kitchen gardens, fisheries and horticulture. The Jurain project integrating health and nutrition, although not strictly a health education project, is building a health care model based on self help by the community. People are taught health care and to raise home gardens and poultry. Slides, films, leaflets, posters, etc., are used in the health education programmes. Because of low literacy levels, the relatively lower coverage of health by radio and television and their limited outreach, health communication has still to greatly rely on the inter-personal forms of communication. The traditional folk media is also used.

In recognition of the role of media in health education, a central communication coordination committee headed by the Secretary, Ministry of Health and Family Planning, has been established to coordinate the functions of the Health Education Bureau and the attached media units of the Ministry of Information.

Research in IEH has yet to develop fully in Bangladesh. A few case studies to assess the impact of health education programmes have been conducted and through listeners' research units, radio and TV are evaluating their health and population programmes.

BHUTAN

Background Information

Bhutan is the second smallest country in the South-East Asia Region of WHO and is one of the "least developed countries". Its population of nearly 1.3 million (1985) is growing at the rate of 2.0% per year. 87% (1985) of the people live in rural areas. Due to low literacy levels high priority is being given to education in Bhutan. In 1981, 36.8% of adult males and 10.0% of adult females were literate. Life expectancy at birth is 45.6 years (1984).

Health Situation

About 50% of the population in Bhutan is covered by health care (1984). In the absence of a firm database, it is difficult to assess the real health situation in Bhutan. However, from the data available it is observed that water-borne diseases and parasitic infestations are widely prevalent in the country. Among the other endemic diseases, goitre, malaria, tuberculosis and leprosy constitute major health problems. Infant mortality rate is estimated to be 102.8 (1984). Diarrhoea seems to be the major health problem among children. Although it is suspected that malnutrition may be widely prevalent, available statistics from a Thimphu clinic do not suggest so. Only 2% of under-fives were found to be below 6% of the median Harvard weight-for-age standard.

Anaemia among women of child bearing age is estimated to be as high as 80% attributable perhaps to hookworm infestation.

IEH Development

IEH is a major component of PHC in Bhutan. There is, however, no specific allocation for health education under the health budget. A health education unit at the National Institute of Family Health has been established recently.

Health assistants, basic health workers, auxiliary nurse-midwives, etc., receive pre-service training in health education at the Health School in Thimphu. Through group teaching and role play, village health volunteers also receive some orientation to health education. Health education efforts in Bhutan have been largely directed to rural populations in the areas of sanitation and drinking water, immunization, maternal and child health and communicable disease control.

Health communication has been mainly through the inter-personal verbal medium. Some materials like charts, folders, posters, flip books, handbooks, video films, tape slide programmes, etc. have also been developed. Recently, the Government of Bhutan has recognized the need for Development Support Communication (DSC) and a detailed list of proposed DSC health programmes has been drawn up. Films, slides and other transparency materials will be produced on a variety of health topics, e.g. sanitation and safe drinking water, immunization, communicable disease control and maternal health. Of the mass media, press and radio are used for health communications and health exhibitions are held from time to time.

There are no inter-sectoral linkages in IEH existing currently although this is envisaged at the district and block levels. Similarly monitoring and evaluation systems are also yet to develop.

Lack of an organizational structure for IEH, low literacy levels, scattered populations having different languages and cultures and an inadequate communication system are the main stumbling blocks to the development of effective IEH programmes in Bhutan.

BURMA

Background Information

Burma is largely an agricultural country, with 76.8% of the population living in rural areas (1985). The population is estimated to be about 38.5 million (1985) with a growth rate of 2% per annum, 38% of this population is under five years of age. The adult literacy rate in Burma is 81% (1985). Life expectancy at birth is 59.3 years for males and 64.0 years for females (1984).

Health Situation

About 44.6% of the population in Burma are covered by health care (1985). Like many other countries in the Region, the health information system suffers limitations especially with respect to accuracy of data on national estimates. Communicable diseases like diarrhoeal diseases, malaria, T.B. and leprosy persist as major health problems and malnutrition is common in rural communities. The infant mortality rate (IMR) was 31.3 in 1984. It is believed that the IMR in rural areas is about three times as much as in the urban areas. Maternal mortality rate is high, about 4.6 in 1982. Abortion ranks among the leading causes of death in women as reported from some hospitals.

Maternal malnutrition, protein energy malnutrition in children, nutritional anaemia and goitre are important nutritional problems.

IEH Development

Public Information and Education for Health is an important support programme in the development of primary health care in Burma. The aims of the national policy on health education are:

- (1) to ensure increased mass participation, and
- (2) develop the health education activities by maximal activities of all mass communication techniques.

The main focus is on peripheral health education services, with involvement of the community and the non-health sectors having a direct relationship with the national health development.

The Central Health Education Bureau participates in planning and providing support for the country's People's Health Programme (PHP) III (1986-1990). The Bureau deals with the following six areas:

- (1) Developing Health Education Programmes
- (2) Mass Communication and Education Programmes
- (3) Production of Education Material
- (4) Training, Field Demonstrations and Community Organizations
- (5) Research and Methodology Testing
- (6) Museum and Exhibitions

In addition to the Central Health Education Bureau, there are state division health education bureaus. To strengthen these, a modified organizational set up has been proposed and is being implemented as a phased programme. The main activities of the programme aim at transferring the responsibilities to the community for their own health matters. These include health education manpower development, group educational activities, strengthening of mass media programmes, production of education support material, institutional development, equipment and supplies, integration of IEH into protected water supply and basic sanitation programmes, initiation of hospital/clinic education programmes, research on behavioural aspects, curricula for postgraduate courses, fellowships for health education specialists, collaboration with other agencies, including non-governmental organizations, and provision of technical support in specific information and education related areas. The main focus of health education is on the peripheral health education services, community involvement and involvement of the non-health sectors having direct relationship with national health development.

Research in behavioural sciences, health education and community participation is undertaken in collaboration with academic institutions. The results of such research is used for decision making on appropriateness of IEH activities for specific population groups and other learning resources.

DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA

Background Information

The Democratic People's Republic of Korea is estimated to have a population of 18.8 million (1982) with 59% of the population living in urban areas. Industrial growth in this Republic has been reported to be remarkable during the past three decades. A policy of universal free education has led to a 100% literacy rate in the country. Life expectancy at birth is 74.0 years (1980-85).

Health Situation

It is reported that 100% of the population in DPR Korea is covered by health care (1984). Health statistics of the country indicate that the population has attained a high level of health. The infant mortality rate is estimated to be as low as 10.0 (1980-85). With the control of communicable diseases, the non-communicable diseases are now on the rise and are of concern, especially the ischaemic heart diseases, hypertension and stroke and neoplasms.

IEH Development

Health education has been accorded high priority in the public health programme of the country. An extensive organizational structure for health education exists.

At the central level, there is a Health Education Institute, directly under the Ministry of Public Health. Each province also has a Health Education House at the city and district levels. There are health education officers at each of the Hygiene and Anti-epidemic stations. The Central Institute gives guidance to national health education activities, trains health educationists, conducts research into organization and methods of health education and publishes health materials. The provincial health education houses also provide training and organize exhibitions. At the peripheral levels, health education is carried out by doctors and nurses.

Specially trained health education professionals carry out the health education programme in the country. In addition, all doctors and nurses,

in whose training curricula health education is included, also impart health education. At the community level, health activists selected from among housewives, workers, farmers and staff of institutions are given short-term courses in health education. Students are also oriented through introduction of health education in the school curriculum.

Health education efforts are directed towards promoting 'self care' in the population through the use of traditional medicine. The other problems addressed are hygiene and control of communicable diseases.

The mass media – press, radio and television – are used to disseminate health messages. Pamphlets, posters, leaflets and periodicals are other aids used. Health education is also propagated through literature and the arts. Health education in DPR Korea is an inter-sectoral activity. Industry, agriculture, education and public propaganda sectors, all participate in involving the masses in health promotion.

In DPR Korea, a health education assignment system exists whereby all doctors, assistant doctors and nurses, excluding those working in teaching and research institutions, impart health education to certain households, institutions and workshops on a regular basis. Student health education teams have also been set up to propagate health knowledge in public places and buses.

INDIA

Background Information

India is the most populous country in the Region, with a population estimated at 685.2 million in 1981 and a growth rate of 2.2% per annum. The population is young – 39.3% being under 15 years of age. 76.7% of the population live in rural areas (1981). Despite its wide educational infrastructure, literacy in India is still low. In 1981, 48.0% of adult males and 24.0% of adult females were literate. Life expectancy at birth was estimated, in 1984, to be 55.1 years for males and 54.3 years for females.

Health Situation

About 75% of the population in India are covered by health care (1983). Although significant progress has been made in the last 3 to 4 decades in raising the health status of the population, the continued prevalence of communicable diseases and malnutrition remain major health problems. The infant mortality rate is still around 100. Diarrhoeal diseases and malnutrition among children are common. Only 15% of children are considered as adequately nourished. 25000 children become blind every year due to vitamin A deficient diets. Iron deficiency anaemia is common, especially in women and children. An estimated 61% of women in the child bearing age are anaemic. Maternal mortality is high, ranging from 0.4 to 13.4 per 1000 live births. Female death rates are higher than male death rates for almost all age groups under 45 years. Tuberculosis, leprosy, water and vector borne diseases are other major concerns.

IEH Development

Health education is a part of India's national health programme using the PHC approach.

A phenomenal increase in the health education budget by 102.8% in 1986-87 reflects the urgency felt by the Ministry of Health and Family Welfare to improve health communication in the country, especially in the field of family planning and welfare.

There is an extensive organizational structure for health education in India. The Central Health Education Bureau (CHEB), established in 1956 under the Ministry of Health, is the apex body for health education and information services. At state levels, there are state health education bureaus and district health education units. These institutions are involved with planning, training, production and dissemination of materials and evaluation. There is no formal organization beyond this level.

CHEB is a large organization having separate divisions for training, research and evaluation, media, school health education, field study demonstration centres, administration and health education. The Bureau provides guidelines for the organizational set-up and functioning of the state and district health education units. Media, training, administration, field

study demonstration and school health divisions also exist at state levels. At district levels, the health education organization plans, implements, trains and evaluates programmes.

To man the large health education organization of the country there are doctors, social scientists and media personnel. Training in health education is offered for medical and paramedical personnel at four training institutions through a one-year diploma course. Besides this, there are several inservice training programmes for paramedical staff, media (including mass media) personnel, key trainers, nurses and health educators. In 1979, a wide-based communication training course was conducted for 50 officers of the Ministry of Health and Family Welfare. Health education is also included in the medical and nursing curricula and in the training curricula of workers in social work, agriculture, rural development, etc. At the community level, health education is taught to village health guides through pre-service training programmes. Health education efforts have been specially directed to women and school children and to eligible couples in family planning. Health education has also been developed for involving traditional birth attendants and formation of health committees at peripheral levels.

In India, there has been extensive production of health education materials like leaflets, pamphlets, etc. The traditional media of song and dance and puppetry are also used in certain areas.

The media are being increasingly involved in health education and particularly for adoption of the small family norm. A media division was established under the family welfare programme of the Ministry of Health and Family Welfare in 1963-64.

India is also making planned efforts to utilize mass media for IEH. Press, radio and television are being increasingly used to disseminate appropriate messages. Recently, a high level coordinating committee has been established at the level of the Ministry of Health and Family Welfare to coordinate, guide and monitor media programmes in health with further advisory committees functioning at state levels. With respect to inter-sectoral collaboration, a close liaison is maintained with the Ministry of Information and Broadcasting. A Directorate of Audio-Visual Publicity, directly under the government, which undertakes campaigns for various ministries, also does the same for health through press advertisements, posters, folders, brochures

and exhibitions, both at central and state levels. The Ministry of Health and Family Welfare also coordinates with Ministries of Agriculture and Rural Development. It has also now become part of a larger Ministry of Human Resource Development which includes Education, Social Welfare and Women and Child Development. To some extent, inter-sectoral coordination is also seen at state levels involving Ministries of Education, Social Welfare, Agriculture, Public Relations, etc.

India has undertaken several research studies in the field of health education through its national training institutes and universities. Much of the research relates to the health guide scheme and the training programmes of traditional birth attendants (dais). Community responses to immunization and health education in schools are some of the other areas researched.

INDONESIA

Background Information

Indonesia is the second most populated country in the Region with a population of 161.5 million (1984) and a growth rate of 2.3% per annum. Children below 15 years account for 39% of the population. Only 22% of the Indonesian population live in urban areas. 73.3% of the population aged 10 years and more are literate (1981). Life expectancy at birth is 56.5 years for males and 60.0 for females (1984).

Health Situation

Despite a significant overall improvement in the health status of the Indonesian population, communicable diseases, especially gastro-intestinal infections, respiratory illnesses, neonatal tetanus, malaria and leprosy, continue as major health problems in the country. The infant mortality rate stood at 98.0 in 1980. Deaths among underfives still account for 47% of all deaths in the country. Diarrhoea in children is a major concern. Malnutrition is also prevalent. 30% of "underfives" suffer from some degree of protein energy malnutrition and, at least, 3% are classified as severe cases. 70% of all pregnant and lactating women suffer from nutritional anaemia.

Some new emerging public health problems are cardiovascular and cerebrovascular diseases and accidents.

IEH Development

The national policy on primary health care in Indonesia includes health education. The budget for health education has been increasing every year since 1979 and forms about 1-2.3% of the total health budget.

The health education organization in the country comprises a Centre for Health Education at the central level under the Ministry of Health. There are also health education units at provincial and district levels that have communication, community participation and school health sections. The main function of the health education organization is to plan, implement, monitor and evaluate health education activities and to develop educational materials, methods and technologies to be used for health education in the various health programmes in the country. Health education specialists, medical and paramedical personnel with health education training, and medical personnel, staff the health education organization at its different levels. Beyond district levels, although no organization exists, a member of the health centre is responsible for health education and for encouraging community participation. Health education courses are conducted through five universities. Health education is also a part of medical and nursing teaching at the under- and post-graduate levels. To strengthen health education and communication sciences at the professional levels, a need is felt to bring together all interested institutes such as universities, government and other sectors for this purpose.

In addition, short orientation courses of 3-5 days duration are given to village volunteers, community leaders, etc.

Health education efforts in Indonesia are focussed and directed towards the five priority programmes of the country, viz. malnutrition, immunization, oral rehydration therapy, maternal and child health and family planning and mainly addressed to women attending the 'Posyandu', an integrated service post at village level.

The policy on health education in Indonesia clearly states that for the success of health programmes, mass media, traditional as well as modern, should be intensified for 'Information for All'. Radio, television, and rural newspapers are used for IEH. An integrated information system has been developed through a Department of Information which aims to disseminate

information to people, including familiarization of people with the health care system using rural broadcasting channels and other means. Listeners, viewers' and readers' groups have been formed. As far as inter-sectoral collaboration is concerned, linkages have been developed with various sectors, like religion, agriculture, information, social welfare, family planning and mass media, artists, boy scouts, youth and women's organizations.

With regard to research in health education, three areas are particularly researched with the help of a few studies. These are KAP studies in the five priority programmes, impact of newspapers in health education and community participation in PHC.

MALDIVES

Background Information

Maldives, the smallest country in the South-East Asia Region of WHO, comprises a double chain of more than 1300 coral islands, of which only 200 are inhabited. The country has a total population of 173 000 (1984), of which 78% live in rural areas. The population in Maldives grew at a rate of 3.2% per annum between 1977 and 1981, children under 15 years forming about 45% of the total population. As compared to many other countries in the Region, Maldives has a high adult literacy rate, estimated to be 81.6% in 1977. Life expectancy at birth was estimated in 1982 to be 53.4 years for males and 49.5 years for females.

Health Situation

In Maldives, 100% of the urban population and 97% of the rural population are reported to be covered by health care. The health situation has shown considerable improvement in the last few years, with a decline in the infant mortality rate to 71 in 1982. Reduction in the neonatal mortality rate has, however, not been so impressive due to high incidence of neonatal tetanus. Child (1-4 years of age) mortality too has not shown signs of decline.

Female mortality is another major concern. Anaemia is common. Women go through nearly 10 pregnancies in their reproductive lives. Maternal mortality is estimated to be 3.3-4.1 per 1000 births (1982-85). In the reproductive age groups, female mortality is 50% higher than the male mortality. Even beyond 50 years of age, female mortality is higher than that of males, an experience contrary to that of other countries in the Region.

According to data from eight atolls, 52% of children under 3 years of age suffer from 'moderate' malnutrition and 4% from 'severe' malnutrition.

Due to poor sanitation, epidemics of water-borne diseases occur frequently.

IEH Development

Health education is an integral part of primary health care in Maldives. The budget allocated for health education is reported to be "substantial", with multifold increases since 1979. In Male, the capital, a Health Education Unit functions in the Ministry of Health, under the administrative control of the sole training school in Maldives, the Allied Health Services Training Centre (AHSTC). This unit coordinates with health and health related ministries in providing technical information, equipment and supplies and production of health education materials. It is staffed by a Director, trained in public health, a nurse midwife trained in nursing administration and education, a health education officer who is a community health worker, with special training in health education, script writing and mass media, and a media officer who is also a community health worker.

Every field health worker, nurse aide/auxiliary midwife receives training in health education, as part of the regular curricula at the AHSTC. Health education efforts in Maldives are directed towards developing appropriate technologies in the use of ORS, weaning foods, sanitation and development of home gardens and largely addressed to the isolated island populations. Challenging attempts are being made to elicit cooperation and support from national leaders for child spacing programmes.

Despite high literacy, communication and evaluation programmes are difficult to implement due to the scattered nature of the population living in isolated islands and due to a lack of media personnel.

Radio, television and the print medium, like booklets, pamphlets, health news, etc., are all used for health education. Exhibitions and demonstrations are also arranged. In the islands, person-to-person approach and use of indigenous forms, like puppets, are the common methods employed.

Inter-sectoral collaboration is achieved with the Ministry of Education, through inclusion of health education in teachers training, with the Ministry of Women's Affairs and the Ministry of Information and Broadcasting, through making radio and television programmes, and with the Ministry of Agriculture, through the development of home gardening.

MONGOLIA

Background Information

The 1.8 million population of Mongolia is scattered over a vast geographical area and is growing at a rate of 2.6% per annum (1984). Nearly 49% of the population live in rural areas but only 30% of the rural population live in fixed settlements and the rest are nomadic and migratory. Universal literacy is a major achievement in Mongolia. Life expectancy is 62.7 years for males and 66.6 years for females (1983-84).

Health Situation

Health care coverage in Mongolia is reported to be 100% (1983-84). Statistics indicate that the health status of children and mothers has improved over the past few years as indicated by the infant mortality rate which is 60.0 (1983-84) and by the maternal mortality rate which is 1.0. No major changes in levels and trends of morbidity and mortality have been observed recently. Respiratory and gastrointestinal diseases still occupy a high place in the list of diseases.

IEH Development

One of the targets of the eighth national development plan for 1986-90 is improvement of the health education programme. The budget for health

education is about 0.2% of the total health budget. Among the countries of the Region, Mongolia has one of the highest health budgets comprising 10% of the overall development budget of the country.

The health education organization in Mongolia comprises a Central Health Education House which supervises and coordinates health education activities all over the country. There are also health education rooms at all aimaks, cities and somon health institutes which have open permanent exhibitions on healthy living. Health education is given by physicians and middle-level personnel. Health education workers define priorities in their aimaks and submit their proposals for the national health plan. There are no specialists in health education or separate health education training institutes. Physicians, feldshers and nurses undergo a 2-month training in health education. Health education aspects are also included in the curricula of advanced specialized refresher courses conducted for physicians and paramedicals. Besides these, special courses and lectures are conducted for community-level health and social workers. Health education efforts are specially directed towards problems like hygiene, smoking, alcohol abuse, prevention of infectious diseases and oral rehydration therapy. Women and children, workers in the catering trade and cattle breeders are the targets for the health education programme.

Radio, television and the print media are used regularly for health education. Posters, brochures and exhibitions are other media used.

As far as inter-sectoral activities are concerned, all industrial enterprises and agricultural farmers promote the health of their workers through health education. Special discussions on health are arranged by television and radio, with participation of all health related ministries.

NEPAL

Background Information

Nepal is one of the "least developed countries" in the Region. Its population, estimated to be 15.0 million in 1981, has a growth rate of 2.6% per annum. 93% of the population live in rural areas. 31.7% of adult males and 9.2% of adult females are literate. Life expectancy at birth is 47.5 years for males and 45.0 years for females (1981-82).

Health Situation

The health situation in Nepal is assessed largely by its hospital statistics which indicate that there has been no major shift in the causes of morbidity and mortality over the last few years. A survey in 1977-78 pointed out that 30% of the morbidity was due to diarrhoea, dysentery and other gastro-intestinal diseases. The infant mortality rate is 152 (1981-82); malnutrition is a major concern. A survey in 1983-84 revealed that nearly 20% of children under 5 years of age suffered from third degree malnutrition in some parts of Nepal. It is observed that female children are more malnourished than the males. Endemic goitre is another major nutritional problem. Its prevalence is one of the highest in the world. Other nutritional problems are anaemia and vitamin A deficiency.

Malaria is a serious problem in the terai region. Leprosy is also widely prevalent.

IEH Development

Health education is regarded as one of the important components of primary health care. About 1% of the total health budget is allocated to health education. A Health Education Section under the Ministry of Health at the centre and health education units in the five development regions plan and implement the national health education programmes. They also conduct training programmes, produce and distribute health education materials.

Professionally qualified health educators are posted to the health education units. At the district levels, there are assistant health educators in the six fully integrated districts and health education technicians in the others.

Community health workers are taught health education through field practice. Health education is also part of the teaching curricula of doctors and other health personnel. In the bachelor's programme in public health, health education is offered as one of the major courses and a proposal for a bachelor's level in health education is being considered to strengthen the training needs in health education. The Health Education Section co-operates with various sectors like agriculture, education and culture, water resources, local development and NGOs in areas of training and development of health education. A formal mechanism for coordination between the Ministry of Health, the Ministry of Communications and Training and the Training Institute of Mass Communications is being developed to support national health policies and programmes. The mass media, radio, television, and newspapers are used for health education. Educational fairs and exhibitions are also held. The postal system has also been involved in health education, bringing out folders and first-day issues on different health topics.

SRI LANKA

Background Information

The Democratic Socialist Republic of Sri Lanka has a population of 15.74 million (1984), of which 35.3% are under 15 years of age. Sri Lanka has an extensive "welfarist" policy, designed to protect the poor sections of its population. Sri Lanka has one of the highest adult literacy rates in the Region, 90.5% in males and 82.4% in females (1981). Life expectancy at birth is 66.1 years for males and 70.2 years for females (1980).

Health Situation

In 1982, 90% of the population was reported to be covered by health care. The health situation as reflected by mortality patterns, shows a mixture of features typically found in both developing and developed countries of the world. The infant mortality rate was reported to be as low as 34.4 in 1980.

Malnutrition is a concern in children belonging to the "estate" sector. Other nutritional problems are anaemia and goitre. Infectious and parasitic diseases are major causes for hospital admissions. Of these, 50% are due to

intestinal infections. Recently, there has been a sharp increase in admissions due to heart disease and neoplasms.

IEH Development.

Health education and community organization form one of the components of the primary health care programme in Sri Lanka. The health education budget is 0.4% of the total health budget and has not shown any appreciable increase in recent years. The Health Education Bureau, at the national level, which has trained health education officers and publicity officers, plans the educational component of all the national health programmes. It also trains officers at district levels and provides field-based pre-service training programmes. The central bureau consists of 12 units concerned with health education in hospitals, community, schools, estates, special health campaigns, dental health, material production, publicity, exhibitions, training and research. At the district level, health education officers plan, implement and evaluate the health education programmes. These officers play a major role in formulating district health plans. At the grassroot level, field health workers impart health education.

The Postgraduate Institute of Medicine offers an M.Sc. in health education. Health education is also part of the training curricula of doctors, nurses, environmental health staff and family health workers. School teachers, community health leaders and volunteers, the local health staff and school dropouts selected as teachers in the nonformal education programmes, are also given some health education training by the Health Education Bureau.

Health education efforts are geared towards health technology developments for the control of diarrhoeal diseases, such as boiling of drinking water and preparation of home-based fluids. As far as inter-sectoral activities are concerned, the central bureau works closely with the agriculture, irrigation and education sectors. The Mahaweli project and Curricula Development Centre of the Ministry of Education are examples of such collaboration.

Linkages with media are close. Radio and television cover health subjects as part of the 'development belt' programmes transmitted during prime viewing time. The Mahaweli Community Radio (MCR), initiated in 1981

to accelerate socio-economic development in the new settlement of Mahaweli, includes health education in its programmes. Several national and district level seminars in primary health care have been held for media personnel. Health-related subjects are now included in the curricula for media training. Links are also being developed with the public information sectors of all ministries. Due to the high literacy rate, the print media reaches out extensively. A quarterly health magazine *Sepatha* is being published for the past 28 years. 16 mm films, slides, posters, etc., as the interpersonal forms of communication, are also used in health communications. No important research studies have been conducted in health education, and its need is felt in Sri Lanka.

THAILAND

Background Information

Thailand, with its population of 49.4 million (1983) and a population growth of 1.6% per annum, belongs to the category of middle-income group of countries. However, rural poverty continues to be a problem. About 38.6% of the population are below 15 years of age. Promotion of education and literacy receive high place in national priorities. Adult literacy is estimated to be about 93.1% in males and 86.2% in females. Life expectancy at birth is 60.8 years in males and 64.8 years in females.

Health Situation

Even though a gradual improvement in the health status of the Thai population has been visible over the past 20 years, the incidence of preventable diseases is still high. Diarrhoea and other water-borne diseases are major health problems. Whooping cough, diphtheria, tuberculosis, malaria and dengue haemorrhagic fever are also causing concern. Infant mortality rate has declined to 45.3% (1982) and the average nutritional status of children seems to have improved. However, iron-deficiency anaemia in women is common and the north and north-eastern parts of Thailand are goitre endemic. Non-communicable diseases, accidents and violence are on the increase.

IEH Development

Health education is an essential component of primary health care programmes in Thailand. Since 1979, budget allotments for health education have increased. It now forms 0.13% of the total health budget.

The Health Education Division of the Ministry of Public Health imparts training, produces health education material and collaborates with concerned sectors. This central authority also supervises, endorses and supports the implementation of health education programmes through the health education units established at the provincial level.

Thailand is the only country in the Region that has created a Centre for IEH at the level of the Ministry of Public Health with representatives from health and health related sectors. A national Health Education Committee, consisting of representatives from the Ministries of Public Health, Education, Interior, universities and departments of public relations, has specially been established for health education of the public, informal education and education through the mass media. The staff of the health education organization at central and provincial levels are trained health educators, information officers and media personnel.

Professional training in health education is offered by four universities in Thailand. Recently, a doctoral programme in IEH has been started. Apart from such specialized training, health education is included in the curricula of doctors, nurses, and other health functionaries and short training courses are organized for community level workers.

Health education efforts in Thailand have been largely directed to problems related to drug abuse, rural water supplies, communicable diseases, nutrition, family health, school health, dental health, environmental health and occupational health.

Slides, tapes, posters, booklets, self-taught manuals, etc. are used for health education. There is also increasing involvement of mass media experts in IEH. There are special television programmes on drug abuse. Health programmes for school children are regularly transmitted over radio.

At the villages, the village public address system is used to disseminate health messages and is being researched on its effectiveness. The mass media

are used to create change in the villages through village health volunteers and communicators and to equip health workers in understanding their supporting role for inculcating self-reliance in people. In Thailand, several health education research projects have been undertaken in the context of PHC covering various aspects, e.g. media effectiveness and impact, training programmes, KAP studies, etc.

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