SOUTH PACIFIC COMMISSION

REGIONAL WORKSHOP ON HEALTH EDUCATION METHODS AND TECHNIQUES

Noumea, New Caledonia, 2 - 6 April 1979

REPORT

Noumea, New Caledonia
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I - INTRODUCTION

The Eighteenth South Pacific Conference approved the organization of a Sub-regional Workshop on Health Education Methods and techniques. At the request of the French-speaking territories, the Workshop was changed into a regional one.

The objectives of the Workshop were:

(a) to identify the educational problems in carrying out health services in the Pacific Islands;

(b) to analyse educational methods and approaches which have been utilized successfully in the region;

(c) to introduce innovative approaches and techniques in educating the public about health;

(d) to formulate guidelines for planning, implementing and evaluating health education activities.

The Workshop took the form of plenary and group sessions. This encouraged interaction among the participants and allowed exchange of experiences.

The Workshop brought together representatives from American Samoa, Cook Islands, French Polynesia, Gilbert Islands, Guam, New Caledonia, New Hebrides and New Zealand.

It was officially opened by General Charpin, the Director of the Health Department in New Caledonia, and the Secretary-General of the South Pacific Commission, Dr. E. Macu Salato.

A Steering Committee was elected to ensure the smooth functioning of the Workshop and to adjust the programme according to the progress made by the small groups.

A Drafting Committee was elected to prepare the summary report and provide feedback to the organizers and the Steering Committee.

The Workshop was directed by Miss Bushra Jabre, SPC Health Education Officer. The services of the two consultants, Miss Sun Young Kim and Mrs. Minda Luz Quesada, were made available to SPC by the WHO Regional Office for the Western Pacific and the UN Social Welfare and Development Centre for Asia and the Pacific respectively.

II - PROGRAMME

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
9:00	Opening	Group Work Identification of educacational problems in carrying out health education activities	Plenary II Analysis of successful educational methods & approaches that have been utilised in the Region	Group Work What can be done? = Guidelines	Discussion and final Report
9:30	Break	Break	Break	Break	Break
9:45	Plenary I Country statements on health education activities and techniques	↓	Discussions ↓	↓	Adoption of Report Closing
11:30	Lunch	Lunch	Lunch	Lunch	
13:30	Plenary I Country statements (continued)	Group Reports	Plenary III Innovative approach in health education	Group Reports	
15:00	Break	Break	Break	Break	
15:15	Discussions on country health education programmes	Discussions	Discussions	↓	
16:30	Meeting Steering Committee Drafting Committee				

III - LIST OF PARTICIPANTS

American Samoa	Mrs. Moli Pa'au Health Educator LBJ Medical Center PAGO PAGO. 96799
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SOUTH PACIFIC COMMISSION'S SECRETARIAT	Miss B. Jabre Health Education Officer (Director of the Meeting)
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Mlle M. Couedic
Interpreter

Miss Theresa Markovitch
Interpreter

Miss I. Magele
Secretary to the Meeting

IV - SUMARY OF COUNTRY STATEMENTS

A summary of points raised in the country statements presented to the Workshop is given below.

The major health problems in the South Pacific region are poor environmental sanitation, poor nutrition, communicable diseases such as tuberculosis, leprosy and gastro-intestinal infections as well as degenerative diseases like diabetes and heart diseases.

All country statements stressed the importance of health education as an integral component of the planning, implementation and evaluation of on-going health programmes.

All countries and territories suffer from the lack of trained health educators at all levels.

Health education activities have been carried out in an ad hoc manner and in a sporadic way without proper planning. Most countries and territories have used the radio while some have also utilized television as a means of informing the public on health. Some countries have produced printed materials such as posters, leaflets and pamphlets, but these have had limited utilization. Community education consists mainly of showing films; little attention is given to changing people's knowledge, attitudes and beliefs. Community organizations such as Women's Committees in the Cook Islands, the Gilbert Islands, and Western Samoa have been very useful in providing information and enlisting community participation in health education activities. However, their potential has not been utilized to the full.

In many countries and territories health education syllabuses for primary and secondary schools as well as teacher training institutions are presently being developed in collaboration with the education authorities.

Health educators need to utilize the traditional leaders in the villages and to work with the people with due respect to their traditions, culture and beliefs, rather than going against them.

Health educators have been involved in training other health personnel (nurses, health inspectors, MCH aides, sanitarian aides, village-level workers and others) in health education.

It appears that health education has not been clearly defined and that the role of health educators has not been understood by health professionals. There is therefore an urgent need to educate health professionals about the role of health education as a supportive service to any health programme. A second step would be to educate politicians on the importance of health education and the need for administrative support.

V - IDENTIFICATION OF EDUCATIONAL PROBLEMS IN CARRYING OUT HEALTH EDUCATION ACTIVITIES AND SUGGESTED SOLUTIONS

A. ORGANIZATION

1. Administration

Problem 1: The decision-makers are often unaware of the health education needs of the people.

Suggested Solution: They should be contacted on an individual basis to help them become aware of the needs and provide administrative support to health education programmes.

Problem 2: There is no co-ordination between health professionals, agencies providing health services and health education activities.

Suggested Solution: Health educators and other health professionals from different agencies should get together to discuss ways and means of providing uniform information to the people and avoiding duplication of effort.

Problem 3: Health educators do not participate actively at all levels in planning the educational component of health programmes.

Suggested Solution: The position of health educator should be at the same level as other heads of health disciplines, so that they may be involved in planning the health education component of health programmes at all levels.

2. Staffing

Problem 4: There is a lack of trained health educators and in some cases posts for health educators at various levels do not exist.

Suggested Solution: There is a need to train existing health workers in health education.

3. Training

Problem 5: Many doctors and nurses may not have the necessary understanding and skills to provide effective health education to patients and the public, due to lack of preparation in their basic education.

Suggested Solution: Basic professional education for all health personnel should include courses in health education theory and practice.

Problem 6: There are not many trained health educators in the Island countries and territories because their employers cannot afford to send them abroad for long periods of training.

Suggested Solution: In-country training should be organized.

Problem 7: Some people who are carrying out health education activities in the community have not been effective in their work because of their limited knowledge of health education principles, approaches and techniques.

Suggested Solution: People involved in health education activities, such as community workers, extension officers, members of religious groups, women's committees and civic organizations, and teachers, should have orientation and training in health education.

Problem 8: Nurses and teachers are ideal health educators because of the nature of their jobs; however, they do not feel comfortable in assuming this role because they have not been prepared to carry out health education.

Suggested Solution: Health education curricula should be integrated into basic education, pre-service and in-service training for teachers and nurses, to help them become more confident and competent in carrying out health education activities.

B. PLANNING

Problem 9: Members of the community are not actively involved in the identification of their problems and in planning health education programmes.

Suggested Solution: Members of the community should be involved in all stages of planning, implementation and evaluation of health education programmes.

C. IMPLEMENTATION

Problem 10: There is a communication problem when health educators use language and terminology not readily understood by the people.

Suggested Solution: The health educator must learn the language which will enable him/her to communicate effectively with the people.

Problem 11: Media such as radio and newspapers often have only limited coverage in the Islands; messages do not therefore reach the people.

Suggested Solution: Other channels of communication, such as informal groups and community leaders, should be used.

Problem 12: Traditional taboos and practices are often barriers to people's acceptance of new health information.

Suggested Solution: Health educators should not underestimate traditional taboos and practices, but should use them to support the new information given.

D. EVALUATION

Problem 13: Evaluation of health education activities and programmes is often not carried out. Research to gather information as an evaluation tool is sometimes biassed and not valid.

Suggested Solution: It is essential to establish specific objectives and criteria for evaluating health education activities before the implementation of any programme. It is also essential to obtain baseline information for establishing objectives. Evaluation should be a continuing process throughout the various phases of any health education programme.

VI - PRESENTATION OF EDUCATIONAL METHODS AND APPROACHES THAT HAVE BEEN SUCCESSFULLY UTILISED IN THE REGION

A. VILLAGE WOMEN'S COMMITTEES IN WESTERN SAMOA

The Village Women's Committee in Western Samoa is a traditional community organization to which all the women in the village belong. The strength of the Committee is based on the "Matai" system. Under this traditional chiefly system the village people respect and follow the traditional leaders.

The president of the committee is usually the wife of the highest Matai, and office bearers are also the wives of Matais. The strong leadership is the key factor in the continuing existence of these committees and their voluntary contribution to the village development. They are very interested in promoting the health of the village people and very supportive of the district public nurse's activities. They organize the village clinics; the district nurse conducts the clinic in the morning and spends the afternoon with committee members at the village women's committee "fale". They discuss and decide what is essential to improve local health. Any decision taken becomes a commitment of the committee as well as the village. Committee members are involved from the planning stage and there is group pressure for the implementation of their decisions at the individual and community levels. For example, group pressure is exerted on a mother who does not attend a well-baby clinic regularly and on families who do not keep up the environmental hygiene standard of the village.

B. "TUTAKA" IN THE COOK ISLANDS

"Tutaka", which entails inspection of all houses in the village once or twice a year for cleanliness and sanitation, is a long-standing custom in the Cook Islands. It was already in existence before the establishment of the Public Health Department.

A committee is formed to carry out house-to-house health inspection in the village. The objectives are to raise the standard of sanitation in the village and to get the co-operation of the people in the implementation of the recommendations given.

Today Tutaka is carried out by a Committee composed of a doctor, District Nurses, Public Health Inspectors, members of the Child Welfare Committee and Village Committee, a Representative of the Internal Affairs Department, radio reporters etc.

During the inspection of individual homes and premises the following points are considered: general appearance, tidiness, dwellings, toilets, indoor and outdoor kitchens, indoor and outdoor bathhouses, rubbish disposal, mosquito breeding sites, drainage, food storage and surroundings.

After the inspection the members of the Committee discuss their observations and recommendations for improvement with members of the household. The health inspectors ensure that follow-up is carried out.

The Committee reports its findings to the community and present trophies to the households which have the best standards. A big feast ("umukai") is organized for the Committee by the people of the village on these occasions.

C. HEALTH EDUCATION ACTIVITIES RELATED TO CHOLERA CONTROL MEASURES IN THE GILBERT ISLANDS

There was a cholera outbreak in the Gilbert Islands in September 1978.

Information and education campaigns were conducted over the radio throughout the outbreak. The message was for the people to boil drinking water; to cook food; to wash hands before eating and after using the toilet; and to bring patients to the hospital/clinic when diarrhoea lasted more than two days.

A co-ordination committee for cholera control was organized. It met daily to review developments in order to give proper instruction to the staff.

The health educator, doctor and nurse organized village meetings to encourage people's participation in the preventive measures. As a result, people became very co-operative and practised the four measures advocated.

In order to achieve more effective participation by the people, meetings were held with medical staff, community workers, religious leaders, women's leaders and youth leaders of the various islands to discuss environmental sanitation. Follow-up of efforts to promote the construction of proper toilets and ensure good water supplies was carried out in co-operation with sanitarians.

D. HEALTH EDUCATION DURING A DENGUE EPIDEMIC IN FRENCH POLYNESIA

In 1975, a dengue epidemic (Type 1 virus) threatened French Polynesia. As there is no known medication and no vaccine against this disease, the only way of controlling it was to destroy the vector mosquito by destroying mosquito breeding sites.

The aim of the health education campaign was to obtain fast action and co-operation of individuals and the community for the destruction of mosquito breeding sites.

In order to accomplish this, the following educational activities were carried out.

1. Information: This had to be intensive with an immediate impact; the media used were:

   (a) Television: The political leaders took part in a live broadcast with participation by viewers. Brief messages, interviews, films and demonstrations on "What to do to destroy mosquito breeding sites" were given in French, Tahitian and Chinese.

   (b) Radio: Political leaders, health workers and mayors of districts participated in radio interviews and urged active public co-operation in control measures. Saturday was designated mosquito-control day, as it is the usual big clean-up day among the Polynesian families. Two Tahitian songs were composed by local musicians during the campaign and were played as theme songs every time control instructions came on the air. Broadcasting staff produced series of special features and interviews on their own initiative.

   (c) Newspapers: Public health personnel supplied a series of illustrated articles, and catch-phrases in French and Tahitian. Articles were published free of charge.

   (d) Extension materials for health workers: Information leaflets, sets of slides photographed in French Polynesia and a movie film for doctors and nursing staff were produced for immediate use during the campaign.

   (e) Information materials for political leaders: Extension leaflets on vector control measures were produced for the information of political leaders.

   (f) Information materials for schools: A booklet designed and produced by teacher's college students for primary school teachers gave information on mosquito-borne diseases and mosquito control measures; it included Polynesian legends about mosquitoes and advice on how to integrate this subject into the normal school syllabus.

(g) Information materials for the public: Booklets, posters, stickers for cars and school satchels and stamps with the slogan "Fight mosquitoes every Saturday" were produced. Information of the public through the mass media was carried out intensively for about a month, and then continued on a more selective and personal basis with several communities and groups upon requests to the Department of Health.

2. Public motivation

Fear was the factor which made people seek to learn about dengue and motivated them to cooperate during the campaign. School children were subject to an intensive information and motivation campaign so that they would carry the message home.

3. How was action instigated?

In the initial stages, the health educator was responsible for creating awareness, motivating politicians and the public and seeking the interest and active involvement of community leaders. These were involved in choosing some districts and schools to be in the vanguard of this battle against mosquitoes. The districts and schools were actively assisted by:

(a) A Mosquito Control Committee (MCC) composed of professional and non-professional people. The MCC was the "king-pin" of the whole control organization.

(b) Activities in schools. Mosquito development was studied in class; public health staff came in to give talks; drawing and poetry competitions were organized; school children took part in clean-up campaigns with their families at district level. Once the children's interest was aroused, they were able to share with their parents the information and knowledge which they had absorbed in school.

(c) Action by Town Councils. Refuse collection services were set up, or developed where they already existed, and town councils used the radio to appeal to the public to co-operate in the control of breeding sites. The mayors and their town councillors organized supervision of households to check whether control instructions were being complied with. Where positive results were seen, some mayors wrote a personal note to the family: "Thank you for the good work. Please carry on".

4. Evaluation of the campaign

Evaluation criteria were set by the public health team before the campaign was launched. The criterion chosen as being the most reliable was the number of Aedes aegypti bites recorded per man and per hour.

Relevant figures were as follows:

Date	A. aegypti bites/man/hour
7 March	8.0
28 March	2.3
25 April	2.08
23 May	0.79
23 June	0.8

Evaluation of impact on the public of information circulated

Two people were appointed to conduct a survey. They interviewed people in busy places (markets, bus stops) or by door-to-door visits to every fifth house (random sample). A very large majority of people (98 per cent) had heard about dengue fever. 87 per cent knew that mosquitoes were the cause and had to be destroyed, and 73 per cent expressed the opinion that mosquito control was each and every person's responsibility. More than half the people interviewed (58 per cent) remembered the larva-control instructions given, but a fairly constant gap was observed between the level of theoretical knowledge, which was high, and the practical application of this knowledge.

Impact on districts: After a few months of the campaign, districts where organized refuse collection was formerly non-existent had set up such services.

In conclusion, the success of this campaign can be attributed to good team work between public health professionals and non-professionals and to political support, but above all to the active involvement of the population at both the individual and the community level.

E. HEALTH EDUCATION ON LEPROSY IN NEW CALEDONIA

1. Objective

The objective of the campaign was to reduce the incidence of leprosy in New Caledonia.

2. Educational objectives

Educational objectives were:

(a) to make leprosy patients understand the long-term treatment and follow it;

(b) to make contacts of new cases appreciate the need for preventive treatment over a period of three years;

(c) to change people's attitude, beliefs and prejudices towards the disease;

(d) to promote a better understanding of the disease among medical and para-medical staff so that they could contribute to early detection of the disease.

3. Means

Information was given through newspapers, radio, and television. Contact was made with the people through medical officers and health staff stationed in the rural areas, the Department of Education, town councils and village leaders.

4. Educational materials

These were financed from the budget of the Basic Education Service and by a private organization. They included a movie film taken in the Territory, slides taken in the Territory or provided by WHO and posters and leaflets produced specially for the campaign.

5. Approach

Village meetings were organized with the assistance of health personnel, teachers and village chiefs and back-up from the mass media (radio, television and newspapers).

6. Content of messages

At the village meetings leprosy and its prevalence in New Caledonia were described. A movie film and slides on leprosy were shown; they were followed by discussion on preventive measures and treatment.

7. Follow-up

The health vigils in each village explained in the local language some of the key ideas put forward by the leprosy specialist at the meeting. They provided feed-back to health personnel on reactions encountered in the field.

8. Evaluation

On-going evaluation shows a decrease in active cases and an increase in case-finding.

	Year 1977	Year 1978
Patients on file	585	539
New cases	54	20
Lepromatous cases	12	5

A change in the attitude of the public is indicated by:

(a) an increase in visits to the Raoul Follereau Centre;

(b) an increase in purchases of handicrafts produced by leprosy patients;

(c) discussion of the disease;

(d) local businesses accepting to employ or re-employ former leprosy patients;

(e) the fact that non-infectious patients can leave the Centre without any problems.

The objectives of the programme can be attained through continuing education and follow-up of the patients and their contacts, as was indicated in the evaluation.

VII - PLANNING THE EDUCATIONAL COMPONENT OF A HEALTH PROGRAMME

A. GENERAL

The educational component of a health programme consists of planned information, communication and education (ICE) efforts aimed at creating positive changes in people's health beliefs, attitudes, values and behaviour for the improvement of individual, family and community health.

These efforts are directed towards three targets:

(a) The predisposing factors of the groups at risk: their age, sex, social class, occupation, education, group membership, previous experience with the disease, health beliefs and practices, etc.

(b) The enabling factors: health and related resources such as community groups, opinion-makers, legislators, service agencies, which could be tapped for the provision of manpower, supplies, facilities, referral, recruitment, and follow-up services.

(c) The reinforcing factors: the health staff and their technical skills, attitudes, orientations, organizational skills, etc.

It is essential to define these target groups for an educational programme in order to decide what kind of learning content, themes, methods, techniques and materials need to be utilized, and to facilitate the determination of evaluative criteria and mechanisms.

For the first group, that is the general public and the population affected by the health problem, there are a variety of educational methods, techniques and materials to choose from, including individual, group, mass media, folk media and community approaches.

To mobilize the health and related resources entails the utilization of community organization strategies and techniques, but it is first of all essential that the health staff be adequately prepared or developed in terms of new attitudes, values, skills and knowledge so that they are committed to undertaking educational activities and able to establish a good relationship with the people, including patients, families and the community resources. The criterion to observe in selecting an educational method is whether it provides active participation and involvement of people in the planning, conducting and evaluation of activities.

B. GROUP WORK: Preparation of the educational component of a selected health programme

The Workshop split into groups to discuss ways of preparing educational approaches to three specific health problems. The results of the group discussions are summarised below.

1. Group I. Health Problem: Mulnutrition

There is a lack of trained people capable of carrying out educational programmes in malnutrition.

1st Step: to organize a study to measure the extent of the existing problem and to identify the vulnerable groups.

2nd Step: to train trainers who would later train community workers in educational methods and content.

3rd Step: to organize an educational campaign which would include an information campaign, assisted by the mass media, dealing with consumer education and follow-up by a motivation- and action-oriented programme carried out by the community workers (nurse, teachers, agricultural extension officers, voluntary group leaders, etc.) who have received training in extension techniques.

This would require the setting-up of a national committee which would set the overall policy. It would also require a built-in follow-up and supervision mechanism to ensure back-up support to the community workers.

2. Group II. Health Problem: Infantile Diarrhoea

(a) Predisposing factors

(i) Age - infants.

(ii) Usually after breast-feeding stage or bottle-fed babies.

(iii) Poor general hygiene of households.

(iv) Contaminated water supply, especially during rainy season.

(v) Failure to practice family planning - too many children and no time to care for them.

(vi) Lack of adequate child care by caretakers due to absence of mother (mother working).

(vii) Lack of basic knowledge about signs of disease.

(viii) Influence of local traditional healers - may prevent people seeking other more adequate health care.

(ix) People have more confidence in traditional local healers.

(x) Parents do not view infantile diarrhoea as a dangerous disease.

(b) Programme Objective: To reduce the incidence of infantile diarrhoea.

(c) Educational Objectives

(i) To make family members aware of dangers of infantile diarrhoea.

(ii) To train all health staff to give effective advice on infantile diarrhoea.

(d) Education Activities

(i) For Objective 1 - Public

1. Information channels:
   (1) Radio - must take into consideration the following:

   (a) time, (b) length of programme; (c) frequency of message; (d) languages and dialects of areas; (e) production of special programmes.

   (2) T.V. - relevant in certain areas.

   (3) Villages, through

   - individual contact;
   - identification of people's values and relation to these of education;
   - group approach through religious groups, parent - teacher associations, youth groups, women's groups, schools;
   - clinics/hospital wards.

2. Action by people - must be simple, practical. economical, feasible etc.:

   (1) Preventive measures

   - Protect food and drinking water from flies, dust, insects.
   - Give boiled water to baby.
   - Breastfeeding is essential - instruction in bottle formula preparation and storage when breastfeeding is not possible.
   - Control flies and parasites by the construction of latrines, maintaining clean house and environment.

(2) Treatment

- Stop artificial milk.
- Give small amount of cooled boiled water, coconut juice, carrot water and rice water frequently.
- Bring baby to the clinic/hospital as early as possible.
- Know the symptoms of dehydration - stools, eyes, skin, no desire to drink, dry mouth, vomiting, no urine, general apathy, and depressed fontanelle.

(ii) Staff Development

1. In-service training courses for health staff at all levels.
2. Preservice training.
3. Basic education

Content of training programme:

- Friendly attitude and approach toward people.
- Communication skills and techniques.
- Practical experiences/demonstrations.
- Practice/field visits.
- Be a good example.
- Orientation on local traditional medicine for treatment of diarrhoea.
- Relationship between sanitation and infant diarrhoea.

(iii) Evaluation

1. Number of total reported cases.
2. For reported cases, time when child was brought to hospital.

3. Group III. Health Problem: Scabies

(a) Situational analysis

(i) Nature of the problem: People do not perceive scabies as a disease, accept it as inevitable but do not like to be identified for treatment.

(ii) Incidence: No statistics are available to measure the extent of the problem; however, it is very common.

(iii) Population affected: School children, entire communities, overcrowded neighbourhoods.

(iv) Prevailing attitudes and beliefs: People feel ashamed when they have scabies, as it is recognised that it is caused by the absence of proper personal hygiene.

(v) Health measures taken

1. Preventive measures

- Clean the body.
- Use clean linen and towels.
- Do not share clothes, bedding, mats, etc.
- Put clothes and bedding in the sun as often as possible.
- Boil the clothes of the person who has had scabies.

2. Control measures

- Early treatment is essential.

(b) Objective: To reduce the incidence of scabies

(c) Educational Objectives

(i) To change the attitude of the people toward the disease

(ii) To persuade people to seek early treatment and adopt measures to prevent the spread of the disease.

(d) Health Education Activities

(i) Training of health personnel in:

- the nature and treatment of the disease;
- communication skills and techniques of working with the people.

(ii) Integration with refresher courses for school teachers, women's groups, men's groups, youth groups, religious groups on the nature of the disease, prevention, control and treatment.

(iii) Use of mass media such as radio, newspapers, television and film for disseminating information to the public.

(iv) Organisation of educational activities for the affected populations.

(v) Production of educational materials for the various target groups according to ethnic and religious groupings, language and level of education.

(e) Evaluation

The measures are:

(i) The number of people who come for early treatment at clinics and hospitals;

(ii) Observation of the villages for the improvement of sanitation and personal hygiene in the prevention of scabies.

VIII - SUGGESTED INNOVATIVE APPROACHES IN HEALTH EDUCATION

A. UTILISATION OF MASS MEDIA FOR INFORMATION

1. Radio

Throughout the Pacific region, radio is recognized as an ideal medium for spreading information and stimulating interest in various social and economic subjects. It has the advantage of being comparatively inexpensive in its programming, with an immediacy and flexibility unique among the mass media and the ability to reach people who were once isolated on their outer islands. The strong rural traditions of Pacific Islands make the "talking" medium (radio) an excellent channel for communication of ideas originating beyond the confines of the island.

The educational potential of radio has not been adequately utilised. Its use for educational purposes so far has been sporadic, unplanned and not quite professional. Health talks are usually dull and uninspiring.

Radio is one element which may profitably be used as part of an overall information or education programme. It may have received less than its proper share of attention because its use so far has been of an ad hoc nature. What is required is a strategic approach. In particular, it needs to be seen in relation to other media: how it fits in with the overall programme of meetings and visits being undertaken by field worker personnel, how the broadcasts themselves may fit in with posters, leaflets and other means of communication.

Health professionals and other community workers can play a vital role in providing feedback to the planners by reporting listener reaction, thereby steering the content of broadcasts even more in the direction of listeners' requirements. Health workers could be trained to lead discussions on the content of broadcast programmes, thus involving the community in problem-solving approaches.

Radio and television should be used not only to reach audiences through public health service channels, but also to provide new outlets designed to reach the audience through commercial and other channels. Jingles, spots, slogans, quizzes and other forms of advertising broadcasts should be utilised to support on-going programmes.

2. Printed matter

Newspaper articles, newsletters and leaflets have in general been dull and unattractive. Health educators should try to appeal to the public in the same way as commercial firms do.

B. UTILISATION OF FOLK MEDIA

Story telling, songs, dance, drama, puppet shows etc. have rarely been used in an educational capacity. The Pacific Islands have a rich heritage of rural traditions. These folk media can be used to great advantage in the promotion of healthy living.

C. UTILISATION OF EXISTING COMMUNITY ORGANISATIONS

Pacific Islands are well known for their communal life style. Village committees in one form or another exist in every island. Women's groups, youth groups, church groups and voluntary committees are quite active all over the region. However, more involvement of these groups in health programmes would ensure that the community is committed to implement the programmes at all levels.

D. UTILISATION OF ADULT EDUCATION TECHNIQUES

Many health programmes have failed because health workers assume that their job is to "teach" the people. However, they find that it is not an easy job and that people do not act as they wish them to do.

Recent developments in adult learning can help health workers find alternative ways of looking at the problems. The ideas of two educators, Ivan Illich and Paulo Freire, threw a new light on traditional education and called for learners to be liberated from the traditional way of teaching. Through education, adults must arrive at a new awareness of themselves and start to look critically at their own social situation in order to take steps to change existing conditions.

Several new approaches to learning are being used in adult learning. The following may be utilised in health education:

- Problem - solving approach
- Projective approach
- Self-actualisation approach

The following table compares the functions of teachers, learners and materials or stimulus, and reveals a progression from a maximum teacher role to a maximum learner role.

E. UTILISATION OF GAMES

Simulation games are basically set up in order to provide an opportunity for the learner to analyse situations and learn from them. The questions arise "What is happening?", "What would you do?". On such example is "Coconut Climbers" a decision-making game designed by the South Pacific Commission, which can be used for a variety of different learning groups.

Some well known games can be adapted for use in introducing current health problems. For example, nutrition can be used as a theme for a Bingo game, or dental health used as a theme for "Snakes and ladders".

These are only examples of games which can be educational. The idea is that learning should be fun; otherwise adults will lose interest and all efforts to "educate" people will be wasted.

	Information Model	Problem-Solving Model	Projective Model	Expressive/Creative Model "Self-Actualising"
Teacher Role	Teacher imparts information and skills usually by lecturing and use of drills	Teacher presents a picture stimulus and facilitates discussion of a given concept, topic or problem	Teacher presents an open-ended story or picture-story with a fixed sequence of events. The idea of events in the story comes from the curriculum writer.	Teacher presents only the raw material from which stories, incidents, problem situations can be created and narrated by students. Raw materials include pictures in no fixed sequence and individual figures (flexiflans) with movable parts.
Stimulus	Stimulus has as complete information as possible leaving little or nothing for the learner himself to contribute.	Stimulus has only partial information. Student contributes from his own life experience and gathers additional data to better understand the topic or problem.	Stimulus has partial information both on a technical problem and on the attitudes and other social, psychological and economic influences on the problem. Students supply the rest of the information needed, through discussion, interviews, and consultation with specialists.	Stimulus has no information other than it relates to human beings. Students manipulate it to convey any meaning they choose. The group gets more understanding through discussion, consultation, interviews, and through comparing different creative interpretation of the same stimulus.
Leaner Role	Learner assimilates information like a sponge, from the teacher's mind and from texts.	Learner analyses the concepts or problem, evaluates its importance, considers causes and effects, also considers alternative solutions, decides on action, if any, and discovers skills helpful in problem solving.	The students supply the ending. They discuss the behaviour and motives of characters in the story and in so doing they may project their own feelings, values, beliefs, etc.	The student uses this raw material and his own life experiences to create a new story which the group can discuss. The words and sentences spoken by the students become the basis for literacy exercises.
Emphasis	Emphasis is on mastery of subject matter and on learning by rote.	Emphasis is on learner's use of his own mind for inquiry and problem solving.	Emphasis is on understanding the problem in an integral way with special attention to the hidden influences on the problem. (Socio-cultural and psychological.)	Emphasis is on developing the learner's confidence, creativity, and communication abilities and on problem solving based on subject matter drawn from student's own lives.

From: Perspectives on Nonformal education. Lura Srinivasan, World Education, N.Y. (1977).

ANNEX

GUIDELINES ON PLANNING, IMPLEMENTATION AND EVALUATION OF HEALTH EDUCATION ACTIVITIES

Public health programmes and services which depend for implementation, upon action by the people have a health education component. Health Education is the method of choice to help people learn what to do themselves and how to do it to have better health.

The guidelines should serve as a step-by-step scientific procedure for planning the health education component of all programmes in which it is essential for the success of the programme that the people should play their part well. They follow the same main steps in scientific planning which are: identification of the problem, setting objectives assessment of resources, consideration of possible solutions preparing a plan of action, implementing the plan and evaluating the outcomes.

Although set in the form of questions the guidelines are not meant to be used merely to get replies to these questions. When they are applied to a particular health programme, each question will constitute a step in the scientific plan. The replies to the question should therefore provide information for a comprehensive health education plan, including implementation and evaluation of the health education component of the health programme in question.

The Guidelines

Step 1: Identification of the health problem and consideration of goals in planning a health education programme.

Health education cannot be planned in a vacuum. It is planned in connection with a specific health programme or health service. Therefore, it is essential for the planners to know the health programme or service well and Step 1 therefore relates to the health problem for which health education is to be planned.

1. The Health Programme

a) What is the health programme in which health education is to be planned?

b) What health problem is the programme expected to help in solving? (the specific problem should be clearly stated).

c) What were the considerations in selecting the problem which the programme is intended to solve?

1) How is the health problem seen by health experts/ administrators?

2) How is the health problem seen by the people and what importance do they give it?

3) What is the predicted feasibility of solving the problem?

2. Nature and scope of the problems

1. What are the epidemiological considerations?

a. Magnitude

b. Population group affected

c. Geographical distribution

d. Seasonal distribution

The detailed epidemiological data specific to the area and to period of time would help the health education service to know where to focus the activities.

2. What are the means to solve the problem?

3. What are the implications for health education in (1) and (2)?

3. Phases of the programme

1. What are the phases, the time of each phase and other essential data?

2. What are the specific programme goals - ultimate, intermediate and immediate - which are to be achieved in solving the problem?

3. What are the social implications and social costs, taking into account the people's habits, customs, values and way of life?

4. What likelihood is there of achieving the programme goals, considering people's response, service facilities, personnel and other resources?

Step II: Determination of desired practices in family health and analysis of factors influencing change (educational diagnosis)

Before making an educational diagnosis of the changes that need to be made in the practices of a particular group, it is necessary for the programme planner to indicate the ideal behaviour or practices on the part of the people to achieve the programme goal.

Step II is designed to help the planners to get information on ideal practices and the extent to which these already exist and also to assess the factors that are supportive and those which act as barriers to ideal practices.

1. Programme measures

What are the programme measures to be taken to achieve the programme goals?

The term "programme measures" refers to the activity or group of activities carried out to see that the health or other means are applied or are provided as services to the people needing them (e.g. giving vaccinations, spraying DDT, etc).

2. Acceptability and the people

1. To what extent are these measures likely to be acceptable to the people? Are they in tune with their way of life? Are they feasible?

2. Which health practices should the people accept so that the programme goals can be achieved?

For example, in polio eradication, when vaccination is provided by house to house visits, the action required of the people is only acceptance; however, when vaccinations are given only in clinics or health centres, a different action is required of the people; they must go to the clinic and request vaccination, or accept it if it is given when they visit the clinic for other purposes.

3. Target groups

1. Which population groups should accept each of the health practices indicated in item 2(2)?

2. Which are the target groups for health education? These are those individuals or groups in the population who are in the best position to take action required or to influence its being taken.

4. Present practices of the people

1. Which practices are now being followed by the people, and to what extent is each practice carried out by different population groups in the community?

2. What are the reasons for following or not following each practice listed in programme goals?

3. What current practices need to be emphasized, other modified? Why?

5. Social, psychological, cultural, economic, physical and other factors

1. What are the factors which help support and promote acceptance and adoption of health practices mentioned in programme goals?

2. What are the factors which hinder or limit acceptance and adoption of health practices?

6. Attitude of the people

1. What are the positive attitudes towards health and welfare services, personnel and agencies and what are the experiences that led to such attitudes?

2. What are the negative attitudes and the experiences that led to them?

7. Changes necessary in the health services provided

To bring about the desired behaviour, must any aspects of health services provided directly at home or in the community be supplemented or modified? If so, which aspect and in what way?

Step III: Assessment of apparent and potential resources

Regardless of the need for or objectives of a programme, what can actually be done will depend to some extent - and often to a large extent - upon the resources available, e.g. resources in the form of men, money and materials. Step III is intended to reveal the resources and assess their potential and specific assistance to the health education programme.

1. Workers to be involved

1. What are the different categories of health and workers who could be involved in this programme? What are their regular duties and their training and background in health education?

2. What are the main difficulties to be overcome in involving health and other workers in carrying out health education programme? (training, supervision, budget cuts, etc.).

2. Resources

What are the type and extent of potential contribution, e.g. service, personnel training facilities, funds and the like.

1. Government agencies (health community development, education, agriculture, information etc.).

2. Voluntary agencies.

3. Health training institutions - These may include all kinds of government and private institutions which undertakes the preparation of health workers.

4. Formal and informal leaders (village chiefs, pastors and priests).

5. Other community resources (cultural centres etc.).

Step IV: Establishing the Educational Objectives

Data collected from answers to these questions are indispensible for the planning, implementation and evaluation of the health education component of the programme. A clear statement of objectives is essential for planning the programme and for evaluating it.

1. Health education objectives

Health education objectives should state exactly what behaviour is to be changed in order to ensure the action, exactly what the people are to do, or what change is to be achieved by a certain time. An educational objective is always stated in terms of the action to be carried out by the people concerned or in terms of a change in their behaviour.

For example, the programme goal may be "to give primary vaccination to all newborns", whereas the health education objective would be "to bring about the necessary action on the part of the people so that they will accept vaccination and the programme goal may be achieved". It is emphasized that to bring about this action, there may have to be many sub-objectives, such as providing knowledge on polio as a serious disease, or to the effect that vaccination protects a person, or that vaccination is available at centres in specified places.

2. Is each objective specific enough for evaluation purposes?

If the accomplishments are to be measured a clear statement of the educational objectives will be necessary. The following criteria are suggested:

1. A clear definition of what is to be attained;

2. A clear statement of the amount or degree of intended attainment;

3. A clear statement of the time in which this degree of attainment is expected;

4. A clear specification of the geographic location of the programme;

5. A clear specification of the particular people or the portion of the environment in which the objective is to be attained.

For example, the objective may read, "To persuade parents of children under six months of age in X village to have all these children (100%) vaccinated between 1 July to 1 September 1977. Sub-objectives might include the following:

1. To carry out a house-to-house survey of the village in order to list the names of all the infants under six months;

2. To identify woman's club leaders who can assist with this survey.

The programme success depends on accomplishment of the sub-objectives. Sometimes a sub-objective may not be directly related to heatlh.

3. Provision for evaluation

1. What are the provisions for evaluating the achievement of the educational objectives?

2. Who will be responsible for evaluation?

3. How much staff time and funds are available for evaluation?

4. When will evaluation be done?

5. What arrangements are necessary at this stage of planning for changing programme operations later in the light of evaluation findings?

One of the purposes of evaluation is to have a continuous "feedback" or flow of information from findings, which will form the basis for making suitable modifications in the health services or health education activities or both. The planning team at this stage should ensure that there is in the plan, the necessary mechanism for making either major or minor modifications as may be necessary.

Step V: Development of a detailed plan of operation for health education

1. Baseline data

1. What baseline data about the area and the people to be covered by health education programme will be essential for planning, implementing and evaluating that programme?

2. Demographic characteristics and literacy.

3. Socio-economic status of the people (average income, type of housing, level of education etc.).

4. Social and cultural characteristics. People's beliefs, taboos, customs, superstitions, food habits.

5. Participation patterns and social organization.

6. Patterns of leadership (formal and informal).

7. Level of the people's cooperation as evidenced by the previous programme.

8. Topographical and ecological characteristics of the area.

9. Transportation and population mobility.

10. At what places and for what events do people congregate.

11. What are the channels of communication?

- Mass media
- Indigenous media

12. Physical facilities such as electricity.

13. Other relevant data.

2. Collection of data

a) How will the data be collected?

b) Who will collect them?

c) When will they be collected?

3. Community involvement

What will be its active involvement for health education purposes? (use of existing committees and organised groups, creation of new ones?).

4. Target groups

5. Opportunities for health education

- in the community
- in institutions
- in duties of each category of worker

Which of these opportunities would be useful in reaching the target groups identified?

6. Education activities

1. What educational efforts are to be undertaken to achieve the health education objectives?

2. How are activities timed in relation to one another?

3. For each activity

1. What is the factual or subject content?

2. What educational method will be suitable?

3. What educational media will be suitable?

7. Persons or Organisations responsible

For each activity

1. Which organisations or persons will be responsible?

2. What are the functions and detailed health education duties of each organisation or person?

8. Supervision

The persons who will supervise the health education activities of each worker or category of worker should be specified.

9. Training

- The details of training requirements for each category of personnel should be worked out for each type of training (pre-service, in-service, orientation).

- Details are needed on the content, methodology, period and place of training, and facilities required. (Same applies for community leaders and volunteers).

10. Coordination of the programme

Who will act as the major coordinator of the health education programme to ensure that the plan is carried out and that the results of immediate evaluations are utilised to modify the plan when indicated.

Step VI: Development of a detailed plan for evaluation of health education

The more specific the objective, the better the possibility of making a useful evaluation. It is necessary in the planning stage to set the criteria to determine progress or success and to select the instruments to use in gathering the data.

1. Detailed plan for evaluation

   a) Does each of the health programme goals specifically indicate the time within which the goals is to be achieved the geographical area and population group involved?

   b) Do the programme measures (Step II) indicate the exact way in which the health problem can be prevented or controlled?

2. Educational objectives for evaluation

   a) Does each educational objective (Step IV) indicate precisely what will actually be measured?

   b) Does each indicate when measurements will be carried out?

3. Flow chart of goals and objectives

   a) Do the programme goals and educational objectives fit into flow chart which shows the relationship between them?

   b) Does the flow chart indicate for each educational objective the educational activities which will be undertaken to achieve it?

4. Evaluation of efforts and activities

   What are the educational efforts or activities which need to be evaluated for the improvement of the health education aspects of this programme (Step V, 6).

5. Criteria for progress

What will the criteria of progress or of ultimate success be for each objective?

6. How to measure progress

a) What methods and instruments need to be used to measure progress and ultimate success in view of the baselines?

b) At what levels?

c) By whom?

d) When?

7. Resources for evaluation

a) What resources (equipment, funds, personnel) are needed to carry out the evaluation?

b) What resources are lacking?

c) Where and how can the resources be obtained?

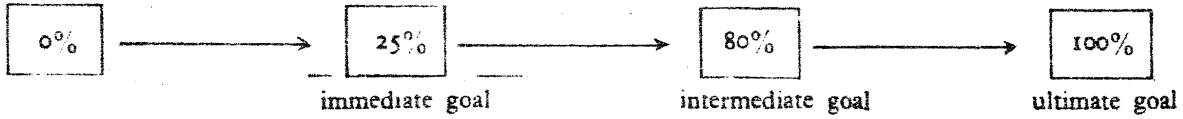
8. Using the results

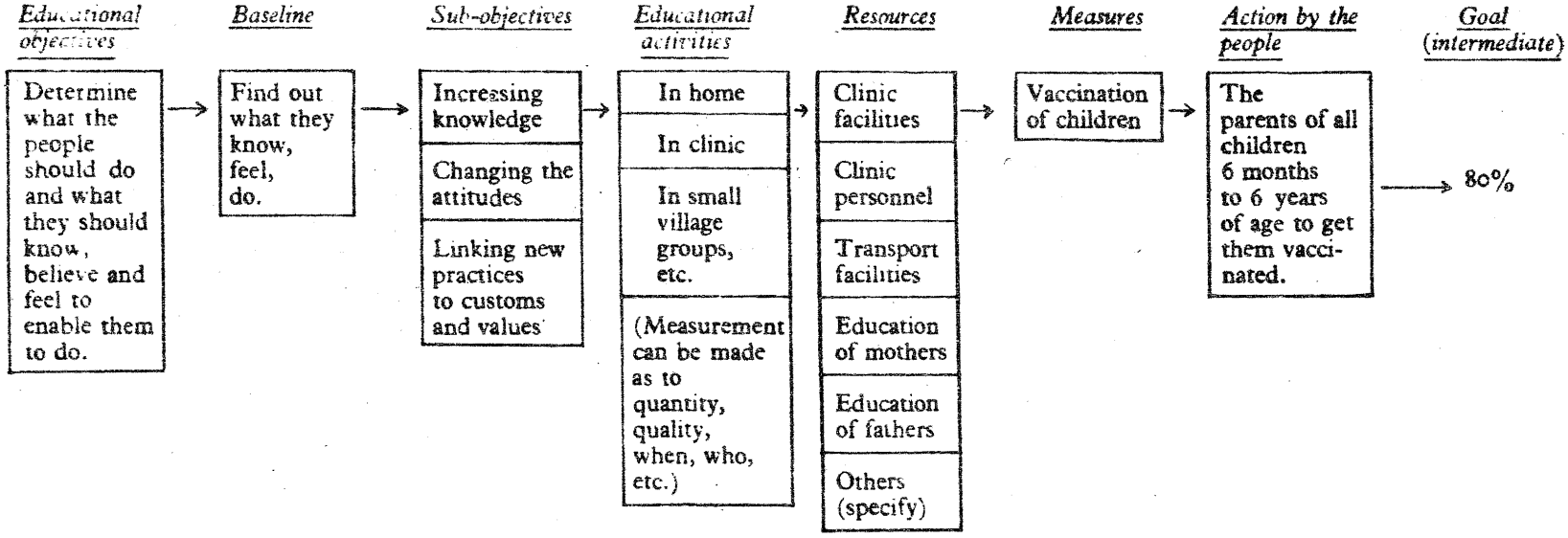
What is the plan for feeding evaluation results back to planners and implementors with a view to improving the programme?

Chart Illustrating Steps in the Plan for Evaluation of Health Education[1]

(Achievement of the intermediate goal)

I





II The programme moves thus :

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[1] This is an adjusted version of the flow chart used by Professor Beryl Roberts in explaining the various steps or actions necessary to be taken to achieve a programme goal. To achieve the intermediate goal of 80% all the actions indicated on the above chart and possibly more would be required. Additional actions required would be indicated appropriately on the chart.

The diagram in II illustrates the use of evaluation as a continuous planning process, i.e. the use of evaluation findings to revise the programme to improve the operations.

* Source: Health Education Comprehensive Guidelines on Planning, Implementation and Evaluation of Health WHO Regional Office for South East Asia, New Delhi (April 1969).