HEALTH FOR ALL BY THE YEAR 2000:
AN EDUCATIONAL PERSPECTIVE
AIDS TO PROGRAMMING UNICEF ASSISTANCE
TO EDUCATION
EDUCATION AND
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I. INTRODUCTION

Health education, nutrition education, agricultural extension work, training in home economics, and family life and planning education are all forms of what is generally referred to as "functional education." Such functional education is geared to impart knowledge and skills needed for appropriately managing a particular facet of individual, family, or community life. As this suggests, most types of functional education relate to services rather than to conventional education, and most are managed by technical specialists with little or no knowledge of education.

Thus, the fate of health education, as well as other forms of functional education, often hinges on how its value is perceived by non-educators; and in fact the opinions that programme managers have of functional education designed to improve their respective programmes tend to vary greatly - ranging from high regard for such education as a key programme component to low regard for it as a mere ornamental frill. Thus, in times of financial stringency the education component often is among the first to suffer resource cutbacks and reduction of its programme role. For this reason functional educators - including health educators - often find their positions threatened, a circumstance that tends to have a negative effect on their performance.

It is also true, however, that health educators are responsible for their precarious situation, for at least three reasons:

First, health education has traditionally been developed as a vertical programme, isolated from the other health services. That is, health educators promoted the idea that they were the only ones who could conduct health education activities; this alienated other health professionals and tended increasingly to place health educators and health education itself in disfavour. It also tended to make health education into an elitist activity - one to be performed in a way very few developing countries could afford.

Second, the vertical nature of traditional health education made it very difficult to measure the contribution of health education to an overall health service programme. And so, because the cost-effectiveness of health education activities was hard to demonstrate, they were often considered ineffective.
Finally, health education was commonly regarded as being limited to the mere provision of promotional information, an activity that was far too narrow and superficial to effectively achieve important changes in the behaviour of the populations served.

Irrespective of who bears responsibility for promoting these ideas, however, the fact remains that health education, when implemented as an integral component of health and development programmes, has much greater potential.

In reality, health education is a tool that can be used to increase community understanding of what the community's health problems are and how the community can become actively involved in treatment and prevention through simple and effective actions, thereby improving its own overall health status. Furthermore, the results of health education cannot be measured by themselves, independently of other health system activities, nor can the goals and objectives of health education activities be defined independently of the overall goals and objectives of other health programme components. That is because health education is not an end in itself, but is rather a tool for facilitating and sustaining changes fostered by specific health programmes.

II. THE EDUCATIONAL PERSPECTIVE

Pursuing health education, as conceived and defined here, does not require any major shift of resources to the health education sector, although some increased allocation of resources will undoubtedly be needed. Neither does it suggest the erection of a health education "empire". Rather it merely requires recognition of an educational perspective - of the fact that education is an essential component in the delivery of health services.

We are no longer talking about training and deploying large numbers of specialized health educators. Rather, we are talking about the need for present and future health professionals to assume their proper roles as educators - roles that constitute an intrinsic part of their work with the community.

The point to emphasize is that doctors, nurses, midwives, nutritionists, and auxiliaries do not merely deliver services; they also provide important education. When a patient needing help comes to the health professional, that patient can generally use advice and guidance - and will tend to be quite receptive to it. Moreover, since those delivering health services tend to be highly regarded by the community being served, they are in a key position to educate the populace about preventive measures, simple disease treatment, and sanitation.
In contrast to the traditional approach, which tended to tell people what was good for them, the PARTICIPATORY EDUCATION APPROACH outlined here provides people with the elements of information needed to assess their situations and find out how to overcome their problems.

 Such education is really a process of acquiring the knowledge, attitudes, and skills necessary for effective self-management of individual and community existence. Within this context, the professionals and para-professionals who perform educational functions are in fact facilitating the process by which people take control of their own lives. In this regard, it is clear that health professionals in particular have an important opportunity - and an important responsibility - to play an educational role in the community.

Another key consideration, one which everyone now recognizes, is that health activities are neither value-free nor culturally neutral. On the contrary, they are the product of particular mind-sets and cultural norms. Therefore, in seeking to modify health practices, health workers are dealing with deeply ingrained family and community traditions. Clearly, changing such health practices requires reorientation of the learning process.

This task is difficult, and if the active community participation envisaged by the primary health care approach is to be achieved, the job becomes even harder.

That is because real participation can only be undertaken effectively by an informed, knowledgeable, and motivated community; otherwise, community participation will continue to be token - a mere justification for outside interventions at best, and at worst, a measure taking unfair advantage of free labour to cut the cost of services.

As this suggests, the primary health care approach demands a great deal of the health worker. It demands the assumption of varied roles ranging from "provider of individual health care" to "community mobiliser". This in turn requires a wide range of skills, among them the ability to provide health education.

Therefore, it seems evident that development of educational skills should form an integral part of a health worker's training. This part of the training process need not be lengthy or sophisticated, nor does it need to consider learning theory or didactic methodology. A lot can be achieved.

1/ The strategy for providing universal access to health services through the extension of primary health care.
simply by instilling positive attitudes towards others, by promoting the use of dialogue rather than the imposition of ideas, by encouraging helpful rather than prescriptive intervention, by promoting true participation rather than control of services from above, and especially, by inculcating a sense of humility about one's own status and increased respect for the community and individuals being served.

III. INTEGRATING HEALTH EDUCATION INTO HEALTH PROGRAMMES

Examination of some specific areas of action more clearly illustrates the need to integrate educational elements into health programmes.

In the field of nutrition, for example, considerable documentary evidence supports the view that socio-cultural factors influence dietary behaviour, so that it is necessary to give thoroughgoing consideration to indigenous conceptual systems in planning nutrition interventions. Thus, a nutrition programme must not only be materially available to a population, it must also be within the population's realm of understanding - an understanding which results from perceptions defined by its particular culture.

Some authors emphasize the need for the nutrition field worker to function as a "cultural broker" mediating between the cultural concepts of the villager and the nutrition programme.

The close connection between this function and the learning process is fairly obvious. Furthermore, when community participation in nutrition programmes is considered a key success of the programmes, the need for increased worker-community rapport and for effective participatory education seems evident.

Likewise, environmental health programmes seeking to expand basic sanitation and water supply services need to make technological solutions work hand in hand with the human element. It is obvious that investment policy, regulatory measures, administrative systems, budgeting, billing, accounting, and engineering are key elements in both the expansion and maintenance of water and sanitation services; but it should also be obvious that the human factor has an overriding influence on the proper use and maintenance of these services.

For this reason, the provision of technical services needs to be supplemented by an informed and responsive coordination and co-operation with the public. Negative

experiences are frequently reported when this human side of the equation is neglected experiences including lack of use or misuse of sanitary facilities, nonadherence to sanitary regulations, poor maintenance and waste, low motivation to use water supply systems, and so forth. Furthermore, rapid progress in the provision and maintenance of basic sanitary facilities relates directly to a community's readiness to demand those services in the first place and then contribute to their maintenance, funding, and proper utilization.

There is thus a clear educational role for the planners, engineers, and sanitarians in their daily work with the community.

Such personnel may of course need training and support to effectively perform such educational tasks, and so cooperation between communicator-educators and technicians is of the essence in order to achieve this end. Another point to note is that in order to be effective, a community health education component should be incorporated into the proposed basic sanitation programme at the planning stage.

Such an educational component has much less chance of promoting community co-operation and a sense of community ownership of the facilities if it is incorporated as a remedial device after the facilities have been constructed and after the community has failed to use or maintain them. In the latter case, the initial progress of the project will often be hampered by disinterest and non-co-operation of the leaders and the community in general, and this attitude may even lead to vandalism of the facilities after they have been constructed.

Of course, an effective participatory approach implies more than extra effort on the part of technical staff members; it also places major demands on its beneficiaries - by asking them to change old habits, adopt new behaviour, accept rules and regulations, and provide financial support. They are expected to do all this when the benefits are not immediately visible and when the demands for their time, energy, and resources must compete with pressing needs such as earning a living in the fields or marketplace.

It is therefore to be expected that health education efforts must play an extremely important role in making the population aware of anticipated health benefits that are not immediately visible.

It is also clear that besides being directed at consumers, health education activities in the field of sanitation should be directed at policy-makers, administrators, and technicians.
The educational methodologies used should vary according to the audience and the stage of implementation of the programme. Such identification of audiences, design and application of relevant methodologies, and scheduling of appropriate activities are all tasks that require careful planning, for which suitably qualified health communication-education specialists should be sought.

IV. HEALTH EDUCATION AND HEALTH FOR ALL BY THE YEAR 2000

Health professionals and decision-makers have increasingly recognized the need to make health education an essential and integral part of the development and delivery of health service programmes. They have discovered that when individuals and families are not intimately involved in the development and maintenance of programmes, such programmes enjoy little continuity of participation or sustained support. In recognition of this fact, the Pan American Health Organization (PAHO) and its member governments have developed a regional plan of action to achieve the goal of Health for All by the Year 2000.

It is significant that health education is viewed as playing a key role in preventive measures by helping to promote positive attitudes and behaviours among individuals, families, and communities. For instance, the section of the plan dealing with the health of special groups emphasizes the following:

- family life education for teenagers;
- development of training facilities and educational materials on health and safety for workers;
- development of educational programmes and information materials to encourage and orient self-care and non-institutional health care approaches for the elderly;
- preparation of information and education materials to promote self-care and care of the disabled by families; and development of manuals, teaching aids, and handbooks for the training of technical and auxiliary workers in simple rehabilitation techniques that are particularly applicable at the community level.

Health education must also be assigned special importance in the sections of the plan dealing with general health protection and promotion, environmental health, disease prevention and control, and (particularly) promotion of community organization and participation.

This may entail some shifting of available resources. It will certainly mean incorporating the principles and methodologies of health education and community participation into training programmes for all health professionals. And it will also involve use of suitable quantitative indicators that will not only measure the impact of health education interventions on the effectiveness and efficiency of health and development programmes and conditions in the countries, but will also indicate what strategies, approaches and methodologies are effective and which ones need to be revised.
Besides expanding the regular training programmes for health professionals, continuing education opportunities will need to be provided in a manner consistent with the requirements of personnel working in the field. In this regard, the process of supervising health personnel should assume an expanded supportive and guiding role directed at improving the health promotion activities that auxiliary workers can conduct in the field.

In general, of course, the scarce resources available to extend health services' coverage will have to be maximized. This implies using resources from all sectors, and necessarily improving the articulation of programme planning, programme implementation, and programme evaluation by all sectors working in communities.

In this vein, agriculture and education personnel can easily incorporate health education information and technologies into the work they are already conducting. This is especially important because such sharing of resources, information, and technologies affords the only way of effectively delivering expanded services to the whole population, the population which is the target of the drive to provide Health for All by the Year 2000.