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COMMUNITY HEALTH EDUCATION: EVALUATION OF PRESENT PROGRAMS, NEW APPROACHES, AND STRATEGIES

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1. Introduction

1.1 Frame of Reference

At the XX Pan American Sanitary Conference held in Grenada in October 1978 the Ministers of Health of the Americas selected for the Technical Discussions of the XXVII Meeting of the Directing Council the topic: "Community Health Education: Evaluation of Present Programs, New Approaches and Strategies."

In various international forums the countries of the world have expressed interest in focusing their efforts on the creation of a New International Economic Order as a basis for improving the health of their peoples. The development promoted will be the outcome of coordinated action in the economic and social sectors, among which health has a leading part to play.

In the health field, the Governments and the specialized agencies of the United Nations system have assumed a commitment to provide "Health for All by the Year 2000."

Two basic strategies have been proposed for attaining this goal: primary health care and community participation. Community participation can be purposively achieved only by including appropriate community health education activities in all programs aimed at preventing disease and promoting health.

This document considers the following concepts and their place in primary health care and community participation:

1. Health education as the channeling of health knowledge into wholesome habits and constructive behavior patterns that will promote the health of the individual, the family, and the community. In this approach, the individual's knowledge and attitudes will help to make his behavior most conducive to his own health.

2. Community health education as a set of methods, means and techniques for enlisting the full and wholehearted participation of the members of the community in actions to benefit their own health, and that of their families and their community, and ranging from the identification of their problems and selection of their priorities to the execution and evaluation of activities and programs for improving their health and providing basic levels of well-being.

3. The community, in the generic sense, as the group of individuals who live together in a particular geographic area, maintain social relations among themselves and recognize that they belong to the community. On this basis, the community in its broadest sense can be a nation, a region or a village.

4. Community participation as a process that engenders in individuals a sense of responsiblity for their own welfare and that of the community, and an ability to act consciously and constructively in the various programs for solving specific problems.

The present document has been written in a conceptual framework in which the ideas relating to community participation as something essential must be reinforced by educational activities in which individuals, families and communities learn to participate actively, consciously and purposefully in the solution of their own problems.

Community education is now recognized as a proper channel for health education to influence levels of information; attitudes and modes of behavior in relation to health, which means that specific approaches and strategies have to be adopted for its full integration into primary health care and community participation activities.

1.2 Background and Resolutions

The countries of the Americas have recognized for some years the value of community health education and the need for the community to participate in the improving of its own health. For this to happen the coverage of the health services will have to be expanded to cover all the inhabitants of every country.

This priority is reflected in statements and resolutions by many of the countries over recent years. The Ten-Year Health Plan for the Americas (1971-80) set as one of its goals "to organize health education as part of the process of active and informed participation of communities in all health actions."

Resolution XXII adopted by the XXII Meeting of the Directing Council in September 1973 following the Technical Discussions on "Community Services and Community Involvement," recommended to thier Member Governments that they "assign a high priority to the formulation and implementation of programs designed to develop in individuals a sense of responsibility for their own health and that of the community and also the ability to participate responsibly and constructively in programs aimed at the well-being of the population."

This resolution also requested support for countries that had already formulated plans for stimulating and encouraging community participation in the delivery of health services, urged other governments to formulate plans for the same purpose, and asked that high priority be given to training in health education for the personnel of health and related agencies, so that training programs that meet the needs of the community might be implemented.

On the recommendation of the IV Special Meeting of Ministers of Health of the Americas in September 1977, the Directing Council decided in Resolution XIV "to incorporate the development of community participation and primary health care into the policy of PAHO as basic strategies and administrative development and the development of appropriate technologies as instruments for guaranteeing health services coverage."

At the International Conference on Primary Health Care held in Alma-Ata (USSR, 6-12 Sept. 1978), it was recognized that "in order to make primary health care universally accesible in the community as quickly as possible, maximum community and individual self-reliance for health development are essential. To attain such self-reliance requires full community participation in the planning, organization and management of primary health care. Such participation is best mobilized through appropriate education."

The same report emphasized that the primary care, community participation and appropriate technology strategies are fundamental for expansion of the coverage of the health services.

> "Coordinated planning at the community level will make it possible to link primary health care closely with other sectors in joint efforts for community development. Thus, community workers can be trained to provide services of different kinds and to complement one anothers roles. For example, the health worker can advise on the importance of improved food storage at home and on the farm and can give practical guidance on this matter. Similarly, the agricultural worker who understands the basic principles of good nutrition can influence the production of appropriate foods and their consumption by families, helped by a local agricultural policy that favours food crops rather than cash crops."
>
> "Community participation is the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their and the

> community's development. They come to know their own situation better and are motivated to solve their common problems. This enables them to become agents of their own development instead of passive beneficiaries of development aid. They therefore need to realize that they are not obliged to accept conventional solutions that are unsuitable but can improvise and innovate to find solutions that are suitable. They have to acquire the capacity to appraise a situation, weigh the various possibilities and estimate what their own contribution can be. While the community must be willing to learn, the health system is responsible for explaining and advising, and for providing clear information about the favourable and adverse consequences of the interventions being proposed, as well as their relative costs."

At the XX Pan American Sanitary Conference (Grenada 4 October 1978) the Ministers of Health of the Americas adopted Resolution XXXIII in recognition of the existence of sociocultural obstacles to the delivery of health care and that the health education and information apparatuses are acultural intrusions into the community, in consequence of which they recommended to the Director "that he give firm support to research designed to discover and develop procedures and instruments of communication as a means to improve health service systems."

The Thirty-second World Health Assembly held in May 1979, when considering strategies for attaining the goal of "Health for All by the Year 2000," recognized that they were not only a responsibility of the governments to the population, but also a social, economic, and technical necessity the meeting of which required that individuals, households, and the community assume greater responsibility for their own health and welfare. Obviously, community health education will be essential to enable the community to provide more care for itself.

Finally, at the opening of the Thirty-third World Health Assembly on 5 May 1980, the Chairman of the Session said:

> "We discussed the flagrant discrepancies of the health conditions between developed and developing countries and resolved that technical cooperation among developing countries is essential so that countries will, by themselves, in learning by doing, foster individual and collective self-reliance. A concerted effort in health education is needed to stimulate interest in community participation and foster the spirit of self-reliance. This stimulus should come from the governments because, at present, health awareness of people in most rural

areas is grossly deficient and our attitudes have to change in order to bring about a revolution in the field of health."

The mandates handed down by the Governing Bodies imply that the Governments and all agencies having anything to do with health and development must take measures to increase the public's knowledge regarding health so that it will be able to participate, both individually and collectively, in the planning, execution, and evaluation of health programs.

1.3 Procedures for Preparing the Reports

It was decided that specific information was needed in order to determine the types of organization and structure of community health education currently in existence in the countries of the Hemisphere.

Groups of experts at two regional meetings designed a guide for gathering information required from the countries. In addition, a number of consultants visited different countries for this purpose, while other Governments sent their reports directly to PAHO.

The information requested was on the following subjects: policies on community health education, standards, personnel in charge of the activities and their training, types of programs that included these approaches, problems identified, and characteristics of the populations participating.

The reports from 23 countries have been processed and the most important findings from the information furnished are presented here.*

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* The participating countries are listed in Annex I, and the highlights of the information obtained are summarized in Annex II.

2. Evaluation of Current Programs - Findings from the Reports

The purpose in this section is to summarize the current status of community health education activities in the countries and their place in national health systems. The activities and procedures described cannot be said to have been evaluated, for the information furnished in most of the reports was gathered in the brief span of a week. The purpose is merely to describe the present situation in general terms, and not to evaluate it in depth.

2.1 Community Health Education as part of the Health System

The information obtained from most of the countries shows the existence of some policy on community participation in health. Some countries are formulating such policies, or else are making them implicit in their national health policies. In some cases community participation is an integral constituent, but in most the expressed policies make no specific mention of community health education as an essential component of community participation.

Most of the countries reports state that community activities are carried out in various sectors--health, agriculture, education, and others--but there is no general use of the multisectoral approach properly coordinated with local, regional or national development activities. This coordination is often practiced informally in individual programs and areas, but not as a national approach.

Technical and administrative standards for community health education do not yet exist in most of the countries or, if they do, have not been adequately publicized among the health personnel and the population.

At the national level mention is made of divisions or departments, generally of health education or community promotion, both in the health ministries and in other ministries (agriculture, education, etc.), in a few instances with multidisciplinary teams.

At the regional level there are generally specific promotion and information programs carried on by professional or technical staff such as health agents, health promoters, health technicians, health officers, etc.

The promotion, supervision, and technical advice functions are performed at the local level by regional technical personnel acting as liaison with the services at other levels.

Few of the countries participating in the study report the existence of multisectoral agencies at the national or regional levels which have broad economic and social development responsibilities and place emphasis on health programs.

2.2 Programming and Planning

The components of community health education are often programmed at the central level, relying little on regional or local studies that could provide a basis for planning the program in keeping with the characteristics of the target population. The countries reports generally refer to priorities of a technical nature, and practically in one case alone did the community transmit its priorities to those responsible for the program.

Program planning runs into difficulties when there are no prior studies or proper analyses of priorities and alternatives, and this creates problems in programming and financing as well.

There is no mention of the gathering of data on activities carried out, or on the classification of results and statistical handling of data.

The effectiveness of the program in its aspects relating specifically to community health education is not evaluated.

2.3 Methods and Techniques

All the countries are using the traditional passive methods of health education, such as mass media, audiovisual materials, photographic story strips, lectures, talks, etc., in health centers, schools, churches and similar centers. Some countries are actually involving the community in health activities through theatrical productions, songs, fairs or "health days", etc.

Personal contacts are also being made through house visits by personnel of the traditional or the formal health system. Community education activities in which group dynamics techniques are applied are being conducted in schools, health centers and other community forums.

In several cases members of the community with special abilities in areas such as leadership and promotion are being trained. Special health skills of other members (those of traditional healers and traditional birth attendants) are gaining recognition and are being

brought into community health education activities designed to enlist the community's participation in the programs.

Integration and coordination of the educational and promotional activities of personnel of different sectors (education, health, agriculture) has a greater tradition at the local level, where it has been achieved more often, and possibly more easily than at the regional or national levels.

2.4 Resources

The reports indicate the existence of health educators employed in community health education functions in several countries. This personnel is usually placed at the national, and occasionally at the regional level. It is not generally specified whether they have been properly trained for community education.

Participation by other professional and nonprofessional personnel (physicians, nurses, nursing auxiliaries, health auxiliaries) in community health education is also mentioned.

Regarding the material resources needed for community health education activities, it is reported that audiovisual materials are in short supply, and that much of what is currently available is inappropriate. There is a lack of much of what is needed for community health education activities to promote or facilitate community participation, such as transportation, some materials to initiate activities, and time specifically set aside for educational activities for the professional staff.

2.5 Personnel Training and Instruction

The spectrum of personnel training in community health education ranges from formal academic courses leading to a master's degree in public health, with the accent on health education, to brief training and refresher courses of one week's duration.

In some cases the countries have sent professionals to take courses abroad. Regional-level courses vary widely in duration, depth, and approach, and either emphasize illness prevention and health promotion, or else basically the curative aspects. The specific community health education content of these courses is not known.

At the local level the training activities are specifically for the health programs in progress, such as the training of traditional birth attendants working in maternal and child health programs and of health promoters working in environmental sanitation programs. These courses are generally of very short duration. Nothing is said about the type or content of the community health education components.

There is no report of the existence of any system of continuing education for health personnel working in the provision of services or for the participating members of the community.

Nothing is specifically known about the health information imparted by teachers to primary and secondary school children, or about techniques of community organization or education for school children, although some countries do report the development of program content in education for family life and community health in schools and communal centers.

2.6 Research

Most of the countries which reported conducting some research for health education purposes referred to socioeconomic surveys or studies of knowledge, attitudes and practices in the community. In a very few cases is reported that studies were done prior to the planning of a project; however, there is no mention of any participation by the community in the identification of its own problems.

Most of the studies mentioned were limited inquiries into the effectiveness of certain methods, measures or procedures in bringing about changes in behavior.

Many studies of communities were never even utilized because they had no operational value. It is not stated if the health personnel who could perform applied studies for staff training and project planning regard this as a priority function or if they are allowed the time and resources to carry out such activities.

2.7 Specific Programs

The information furnished by the countries on specific current programs in which community education is used to obtain community participation in particular health activities reveals a wide variety of approaches, of which, therefore, only a few will be mentioned:

- In food and nutrition programs, "nonformal" personnel such as young people, parents, teachers, etc., are often trained to assist, mainly in the distribution of food supplements. In other countries there is coordination with other sectors connected with the production of foods for family consumption in communal forms and under other arrangements.

- In environmental sanitation programs, which in many countries are carried out by other ministries or by specialized departments of the health ministries, community education focuses on obtaining contributions of materials and labor from the community for water supply and waste disposal projects. The community is involved in home maintenance and cleaning up the environment through traditional activities and religious festivals.

- Health education activities in marginal areas are being slanted primarily toward such aspects as education for family life, sex education to prevent unwanted pregnancies, the prevention and control of alcoholism, smoking and drug addiction, the care and treatment of the teeth, and, in the mental health field, information and counseling on emotional problems. These educational activities are carried on with the cooperation of private associations, parents and young people, non-school and vocational programs, and universities and teachers.

- In immunization programs and the detection and referral of cases of communicable and parasitic diseases, many countries employ traditional healers and youths trained as community health volunteers. In addition, community health committees are being formed through which the community joins actively in the identification, prevention, and control of communicable diseases.

2.8 The Community

The community health education activities reported by the countries are concentrated especially in rural and marginal urban communities. In certain countries the emphasis is on expanding the coverage of the health services to the rural and outlying areas, while in others, as a result of demographic and economic phonemena brought about by growth and population movements, health programming focuses on the communities of migrants from the countryside who settle in slum belts around cities. Some countries adopt a dual approach toward both rural and urban areas.

Health programs stress increasing community participation through organized groups or by forming health committees. The involvements of members of the traditional community health systems (midwives, healers and leaders), accompanied by appropriate training, has been tried on different occasions. The school has often been the first step in establishing health programs in the community on a sound basis. The church, too, has played a very important part in the identification of health problems and the conduct of communal activities leading to their resolution.

Availability of community resources is cited as a factor worth considering when planning activities in which the community will participate. Efforts to obtain funds and contributions of local materials are important for furthering these programs.

Finally, the organization of the communities themselves is emphasized as the key point in community health education, especially when community members are involved as individuals and families.

2.9 Factors that Promote and Inhibit Community Health Education

Several factors have been identified, some of which appear to contribute to the success of community health education activities and to prompt the active participation of the community in health and development programs, and others of which act as obstacles to those activities and that participation.

Most of these factors pertain to the structure and characteristics of the health programs, while some seem to be the product of the characteristics of the communities and of their social dynamics. The existence of policies and standards for working with the community, when circulated at all levels, created the most favorable conditions for joint action by the people and the health personnel. The interest shown and support given by the members of the health team in their contacts with the community have been one of the keys to success. Technical and financial support that reassures the community as to the feasibility and viability of the activities and projects has also been important. Another factor frequently mentioned as contributing to success has been when the health team has listened to the community and has lent its support in the solution of problems of local concern instead of trying to impose national programs from above.

Other identified factors were the technical and financial cooperation of international, bilateral and private organizations, the continuity of health staff in activities within the program, and respect

for the community's folk system of traditional birth attendants, lay healers and other such practitioners. The participation of school teachers is also given weight in some countries.

Some characteristics of the populations themselves were cited as important factors favorable to community participation, such as the presence of progress-minded leaders and a flexible community organization with a sense of social unity and receptivity to innovation. Participation by community volunteers in activities within the program, informing members of the community in formal and informal groups about the goals and purposes of the program, reinforcement through the mass media, minimization of the resources needed to support the program and visits to neighboring communities to learn about their gains from community participation, were found to be among the most important ways to involve the community in health actions.

Among the negative factors cited were many problems that raised barriers to community participation and community health education. Often mentioned were the conventional curative care and intrainstitutional approaches, the lack of integration of the members of the health team, the lack of multisectoral approaches and the indifference of health personnel toward or indeed their scepticism about the usefulness of approaching the community and mobilizing its great potential for the attainment of goals in the improvement of its own health. Moreover some of these factors can become barriers to community participation when there are not enough or any staff trained to promote community health education activities.

A community's poverty or lack of resources, its scepticism about what the program offers in the light of past experiences, the dispersal of rural settlements and their low educational and economic levels were identified as problems inhibiting community participation. In one case only were the socio-cultural characteristics of the people mentioned as barriers to the programs.*

2.10 Summary and General Conclusions

The establishment of the New International Economic Order sought by the countries of the world is based on concerted action by the economic and social sectors. Among these, the health sector in all the countries is committed to achieving the target of "Health for All by the Year 2000."

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* Annex III sets out the factors identified by the participating countries as favoring and hindering community health education.

According to the data obtained from 23 countries, community participation is included in some form in all their policies, but community health education is not generally mentioned as the means for achieving it. The majority of the countries have not carried out health activities in coordination with those of other sectors. Technical and administrative standards for community health education are either lacking in almost all the countries or else have not been adequately publicized.

The foregoing suggests that low priority is assigned to intersectoral programs, the systematic incorporation of community education into the countries' health programs, and the implementation of strategies that will involve the community in the planning of the programs and ensure that the latter's interests are taken into consideration.

In all the countries there is some type of administrative structure for health education activities at both the national and regional levels. There are not personnel designated specifically for this purpose at the local level. Personnel with appropriate training for community health education are hard to find at any level from which it can be concluded that this approach is not being adequately employed at this time. It can also be concluded that community health activities are of low priority for those in charge of health programs.

Most health programs are implemented from above, with minimal or no participation by the recipients of the services in their planning, implementation or evaluation. The absence of community health education means that the programs are carried out in the manner that is best for the health system, but not necessarily for the interests of the population. This can also be a reason why the facilities are not fully used or properly maintained.

There are generally deficiences in the countries' information systems, which hinder the timely supervision and evaluation of programs in progress. In the specific case of community health education, not only is adequate basic information lacking, but also suitable personnel to perform the educational functions, including information, supervision, and evaluation at all levels.

Educational materials for community education in health are in very short supply, and what exists is unsuitable and outdated. Most programs have limited budgets for their production. Instead of being consolidated, resources are still used in a fragmented way, which considerably reduces the efficiency of producing the materials and raises their total cost. Reference materials are in similarly limited supply, which leads to both shortages and duplication when they are produced in isolation.

The lack of adequate appropriations for these items within national budgets makes it almost impossible to maintain an appropriate level of information about and utlization of the most novel technologies in the field.

3. New Approaches and Strategies

3.1 The Socioeconomic and Cultural Setting for Development

The levels of socioeconomic and cultural development of the different countries of the hemisphere vary widely. Per capita income, education level, health status and general living standards differ greatly, sometimes from region to region within the same country. Hence, health problems cannot be considered in isolation from the social, economic and cultural environment. Economic development depends in many ways on the health status of the population, as do, among other things, technological development, education, and cultural and social homogeneity.

On the other hand, the migration of large numbers of rural people into urban areas is a common phenomenon in the Region and is raising to a critical level three major factors which influence the health of the population:

1. Pressures from demographic changes in urban areas with resulting exacerbation of problems associated with the differing social sectors.

2. The need to face up to a situation being created by urban population groups whose habits, characteristics and skills remain basically rural.

3. The need to allocate more resources to solving problems created by these shifts and, in most cases, to continue serving the rural populations through the extension of coverage of health and other services.

The basic thrust of the new approaches and strategies in community health education is to maximize community action so as to secure the participation of the population in joint activities with health personnel. Such activities include, among others: a) studying the problems facing the community; b) identifying community priorities, resources, and available alternatives, and c) training members of the community for purposeful action in support both of multisectoral and specific health activities in order to solve community problems and meet local needs.

Active and conscious community participation, whether at the national, regional or local level, is regarded as one of the foundations needed to support all actions aimed at development. For this participation to be effective, the community must become aware of its needs and

potential; trained in order to constructively contribute its energies; and, sufficiently motivated and encouraged so that positive changes are of a more permanent nature.

3.2 Community Health Education in the Health System

The new approaches and strategies that communtiy health education seeks to bring to bear on the solving of health problems in the countries make changes and adjustments desirable in the present structures of the health services and other development sectors.

A key strategy for community participation to become an essential factor in health programs, is that a national policy must be established or reinforced to support such participation at the technical and operational levels as a means for achieving the goals of the programs. Hence, the necessary support must be provided so that such a policy may actually lead to the design and implementation of community health education activities as the best way to promote and encourage this participation. This policy will have to be widely publicized and understood by personnel at all levels of the health system and by the citizens themselves, who will have to get involved in the programs.

In countries that have the resources and appropriate means, consideration could be given to establishing multisectoral or intersectoral activities and coordination, in which community health education and community participation play an important part. The process could be progressive, and start with priority programs of immediate interest.

When each country defines its policies and strategies, sets its priorities, and identifies its programs in relation to specific objectives, it becomes necessary to consider the design of suitable standards. With these standards, health programs can be carried out in a satisfactory manner so as to promote community participation in all their activities.

Standards should be set for community health education activities, based upon the organization of a country's health system and existing resources, needs and priorities. They should be adaptable to all programs to ensure that educational activities are both administratively and technically appropriate.

These standards should be transmitted through manuals, directives, official documents and other means to health personnel, who should be fully familiar with them. Both the standards and this documentation should be flexible enough to be adjusted to conditions in each region, area or community.

3.3 Structure for Community Education in the Health System

Governments are extending their health services to low-income urban and rural areas in order to bring health services within reach of the entire population and to deliver the services which meet most of the basic health needs. Accordingly, in order to include community health educational activities in this process, some countries are considering changes in the structure of their services consistent with their resources and with emphasis on the following:

At the national level, establish a standardized health education service, staffed with properly trained and experienced personnel, or strengthen the service where it already exists.

At the regional level, all operating units (hospitals, health centers, etc.), should be integrated and organized to provide care at all levels. All the personnel of these units must take part in community health education activities, the aim being to organize, train and motivate the community to participate in health actions. At this level these activities must be organized and reinforced with intermediate technical personnel, who will support primary health services by furnishing technical know-how, personnel training, guidance, and supervision, logistic support, information, and other services connected with specific health programs.

At the local level, health services personnel will provide group training and instruction in an effort to channel and stimulate the abilities and potential of communities so that they will participate in specific comprehensive health programs, possibly in coordination with activities of other development sectors.

3.4 Programming and Planning

Programming national community health education activities must depend on the regional and local resources, expectations and needs.

As part of the health sector programming of activities, services and projects, community health education must include the comments, suggestions, aspirations and commitments of the community, and include the cooperation that the institution or personnel involved in the project have undertaken to provide.

The planning process for community health education entails provisions that determine the technical machinery to be used for education, information, motivation and evaluation purposes, on the basis not only of what each country has found to accomplish its purposes, but also what is affordable and compatible with its culture.

For community health education to effectively bring about community participation, the following must be accomplished by both general and specific programs:

- Local actions are programmed on the basis of concrete realities that can be expressed qualitatively and quantitatively.

- The community makes a firm decision to participate in educational activities through its contacts with the individuals conducting them. This means that local plans are drawn up by the community under the guidance of competent personnel.

- Directives, manuals, and guides that are easily understood by the community personnel, are made available .

- Local personnel and members of health committees are trained not only to carry out such projects as water supply systems, housing, etc., but also to manage and maintain them.

The periodic evaluation of all aspects of the program to assess the gains made and needs still unmet must be performed with the participation of members of the community. Of special importance for community health education is the evaluation of the processes that have been carried on during the activities, for a solid theoretical and practical basis has to be established for utilization in future activities and for the recording and exchanges of successful actions to achieve community participation through education.

3.5 Methods and Techniques

The following are a number of general techniques, which are basic to achieving successful community health education efforts and to promoting active and sustained participation of the community in health programs:

a) The health personnel must serve as a catalyst to motivate and guide the population in obtaining the basic data necessary for planning and executing projects, by explaining why this

information is needed, and where and how it can be obtained. Once it is collected, they should collaborate with the community in its interpretation so that priorities can be set. Decisions based on this process will logically be more appropriate and effective in securing community participation than those obtained from projects which commonly impose vertical programs from above. Thus, the purpose of the initial information-gathering process is to make both the population and the health sector aware of local health problems, resources, and the available alternatives.

Health personnel can obtain indications through contacts with members of the community, as to the persons best suited to provide and gather information. Schoolteachers are usually familiar with procedures for school and population censuses; young people and students, properly informed and motivated, could gather data on birth rates, death rates, diseases, and resources. If there is an institute of higher education or university in the area, its students could be encouraged to cooperate with the population and allowed to use the material in school reports or theses.

b) Formal and informal leaders, and the representatives of the community health system should be identified in the process of gathering information about the community. It is particularly important to involve these persons in the design of the project, according them the same status they hold among the people, and working as partners with them to determine the priorities of the community's needs and to select the most viable alternatives. A simplified procedure for identifying community leaders is based on a "reputational" study of the outstanding personalities. Briefly, it consists in asking the community members whom they go to for counsel or guidance on decisions regarding health, investments or settlement of disputes. The representatives of the community health system can also be identified on the basis of their reputation, since, just as there are skillful and conscien- tious healers, there are also a number of charlatans who are known to the people and whose participation in the program activities may be undesirable.

c) It should be borne in mind that the processes of community motivation and orientation are not necessarily focused on health alone, since identified needs may cover many other sectors as well. In order to have the community maintain a proper perspective of its needs and the alternatives available for meeting them, the participation of local or regional

representatives of other sectors (i.e., agriculture, education and housing) should be sought whenever possible. It is accordingly desirable to identify the representatives of other sectors at the local regional and national levels, to clarify their aims and procedures, and to have representatives of the community and the health system meet with them to analyze the identified needs, set priorities, and explore all possible alternatives.

d) Occasionally, community members may be reluctant to participate, mainly because they are unfamiliar with the responsibilities and obligations entailed in such participation as well as with the advantages that may result. It must be stressed that, in motivating members of a community to participate actively in projects, the type of responsibilities and obligations involved should be made clear; for instance, how a committee should function, what kinds of tasks a health auxiliary is expected to perform, or how a population census is to be taken. This instruction is essential and ought to be one of the standard functions of health personnel.

Instruction in these aspects can be provided in a practical, simple, and agreeable way through socio-dramas, discussion sessions by health team members in collaboration with members of the community, and others, such as guests from other communities.

e) Finally, the importance of extensive and frequent feedback must be underscored. Community members, both the active participants and others, must be informed about the gains made in the project, the obstacles encountered, and long and short range plans. This feedback is a valuable stimulus for those who have worked for the accomplished gains as much as for those who, through skepticism or lack of information, have not yet participated actively in the projects.

In marginal urban communities, feedback can be facilitated by periodic bulletins and the organization of "health days" in the schools, health fairs, and other forms of mass assembly. These devices can also be effective in rural communities, if used on an appropriate scale. However, nothing is more convincing than evidence: visits to neighboring communities where health activities have been conducted, interchange of people from other areas to describe personal experiences, wall murals and newspapers in public places (schools, the town hall, and churches), showing the gains of the program in graphic form. These are some approaches already in common use for feedback to the population.

It is clear that community health education in its endeavor to promote and achieve community participation in activities for improving its health, must identify, through the study of local situations, the most important contributing and inhibiting factors. This characterization of factors should support to the extent possible those that favor participation, while seeking to control or change those that inhibit it.

These strategies make no claim to be entirely innovative or new. It should be emphasized, however, that the new approaches in community health education are based more on activities carried out directly with the members of a community, than on the traditional approach of talks, lectures and films which tell the people what to believe and how to act, or in other ways regard them as passive recipients of messages about their own health.

3.6 Resources

The general types of activities and resources needed at the national, regional and local levels were mentioned in section 3.3. Specifically, the health system will need personnel specialized in community health education to carry out the planning, training, research, education and evaluation. The health educator needs the support of the higher echelons in order to function properly as an integral member of the health team.

The community health education specialists, with the necessary administrative and technical support, work both at the national and at the regional levels. One single specialist may have responsibility for various regions or jurisdictions, especially when populations and problems are similar.

While the health system personnel are the primary resource, the community must also be regarded as important.

In fact, the population is the most important resource of any country. The educator knows and must remember that individuals and communities have the capability and potential for improvement, and that his/her function is primarily to stimulate, instruct, and motivate them to improve their health and well-being.

Studies should be made of the leadership, its patterns and procedures, the internal dynamics of communities and the identification and use of their human resources: leaders, young people, teachers, and formal and informal groups. Understanding these elements will enable the educator to stimulate, instruct, and motivate the population. He must emphasize

these insights to the leaders, in order to activate the inner energies of the community and thus bring about improvements that are truly its own. This will assure permanent community support for health actions.

The community generally donates materials and labor for the implementation and maintenance of its health services and projects. Community education will expand community input and facilitate the choice of appropriate technology for those services and projects, enabling the community to participate fully in the proper administration, maintenance, and utilization of those resources.

The financing of community health education activities must fittingly reflect the priority assigned to it in the form of specific budget appropriations for wages and salaries, the procurement of vehicles and educational materials, and possibly the provision of incentives for communities that need not only technical support but also modest contributions of materials or food to enable them to carry out priority actions.

3.7 Personnel Training and Instruction

In personnel training and instruction, a balance must be struck between imparting knowledge and testing this knowledge in real-life situations. Training that consists almost entirely of classroom work and lectures, will inadequately equip the trainee to solve problems not covered by theory; and, training based primarily on practical work, will not provide the necessary conceptual depth for understanding what is being done in the broader context of real life situations.

Training and instruction for personnel in community health education must therefore combine theoretical and practical contents.

The theoretical content should emphasize points covering a span of information ranging from the country's social policy to participation by the community in its own development. This implies giving prospective health education personnel a sense of their own responsibility in the socioeconomic and cultural development of the population, i.e., an understanding of and respect for the individual as part of the program and of the community for which it is intended. It must seek to establish what could even be termed a mystique of cooperation with the community by establishing relationships of mutual responsibility and collaboration. This theoretical part must relate community health education with philosophical and doctrinal principles and concepts, all in the context of promoting the active participation of the individual, the family, and the community in taking responsibilty for their own health.

The practical content should provide the individual with the methods, strategies, techniques and procedures needed to do his job. It should include general and specific information about health and disease, the environment, the health needs of the population, and their relationship with the economic and social characteristics of the country and region.

Besides this general and specific knowledge, and in order to give the trainee a multisectoral approach to his work in the community, important components should be included: community health education methodology and techniques, including techniques for the educational diagnosis of the community, group dynamics, community leadership and organization, communications, and information techniques, characteristics of human motivation, a solid grounding in educational procedures and techniques, social research and evaluation, the social and cultural chracteristics of the target population, and the structure and organization of the health services and of other development sectors such as agriculture, education, housing, etc. The new training courses would be designed by members of the multidisciplinary team, which could include among others, the following specialists:

- A specialist in public health
- A specialist in health education
- A specialist in social sciences (anthropology, social psychology)
- Other specialists, depending on the types of health programs and community health education activities going on in the country.

The community health education specialist cannot work in a vacuum. The professional and non-professional personnel of the health team and the local workers will be responsible basically for carrying out the actions designed to bring about community participation through education. Hence, community education content must be included in training programs for health personnel at all levels, and adapted to the functions of each member: the physician, the nurse, the engineer, the health technician, the health promoter, etc. The health team will also be responsible for the training and instruction of the local staff, which can be provided in basic short courses or on the job.

It is essential to provide for the continuing education of both members of the health team and local workers. Training needs and problems should be identified through supervision of personnel in their jobs, whose efficiency should be evaluated at frequent intervals. This will enable them to identify the areas in which they need more knowledge, so that continuing education activities can be planned accordingly. The expenditures required for health personnel training and instruction

should have priority if participation by the community in its own care is to become a reality. The national governments should explore the possibility of expanding training resources while seeking to collaborate with other countries (in the context of technical cooperation among countries), and with international and private organizations which support this cooperation and facilitate training of national personnel.

3.8 Research

There is currently a need for research in community health education and for periodic and final evaluations of educational efforts. Operational research is considered necessary on two levels: a) basic study of the communities whose participation is desired in order to meet the goals of the programs, and b) in-depth research to acquire a clearer and more precise understanding of social dynamics, human motivation in cooperation and participation, the position health holds on the scale of social values, and barriers to the adoption and consolidation of new behavior patterns more in keeping with the health needs and economic and social developmet of the populations.

Basic studies of communities will furnish information on the community, its perception of its needs, and the most appropriate procedures for achieving the goals of the program on the basis of the interests and motivations of the population itself. The members of the community must be intimately involved in the work of the basic study itself, and the health personnel should promote community interest in obtaining this information and provide whatever guidance is needed. The findings of these studies should be widely publicized among the members of the community. The health personnel, and that of other sectors, may need to interpret the implications of these findings with the population to ensure that the situation may be adequately evaluated, the problems stated, and the working priorities set on the basis of informed decisions by the community.

It will be important to take stock of the technologies and resources with which the community customarily solves its problems and fulfills its needs. These indigenous resources can meet the requirements of programs satisfactorily without the introduction of new and alien technologies.

Research into social and behavioral phenomena should be incorporated wherever possible into the program activities. Health personnel, and especially the health educator, can become involved in studies to learn more about the regional and local decision-making processes, the

phenomena of individual and collective behavior associated with community participation through community health education, and the evaluation of that participation.

3.9 Importance of the New Approaches in Community Health Education

Traditional procedures for providing health services to the public have been geared to a community that was receptive in attitude but passive in its behavior. The aim was to create a knowledge and information base that would enable the individual to form attitudes and adopt behavior patterns that were most favorable for preserving health. The process followed was generally one-way communication from the health team personnel to the individual and, on occasion, to the family. Even when efforts were made to utilize community development procedures, the projects were generally planned and the decisions made at the health team level and almost always without giving the members of the community much advance information or any decisive part to play.

The new approach in community health education poses a challenge both to health personnel and to the members of the community. It is essential to bear in mind that the short-term goals, which are the solution of obvious problems by the population with its own direct participation in all phases, are but the opening stage of a whole process. The real basis for success lies in the permanent changes that are brought about in the social values not just of the community members but of the health personnel as well.

Developing a safe water supply system and conducting immunization campaigns are examples of specific programs which have, through technical achievements, also created a perceptible impact on social values, such as promoting health to a higher place on the scale of social needs, dispelling misconceptions about the usefulness of cooperating for the common good, and awakening in the individual a growing sense of responsibility toward his family and community.

Hence the community must be perceived not just as the object of the program's design, but also in the perspective of being its subject, implying a certain social and cultural transformation of the populations involved.

Community education can serve as a basis for the generation and reinforcement of a group awareness that reflects the yearnings and aspirations of the community. The chain reaction that can be triggered in communities, that change their perceptions and values, can be the starting point for a full working system which will raise the standard of living

for the population. It will be the responsibility of various governmental sectors which are involved in economic and social development, to support and cooperate in meeting the needs generated by the community instead of stifling them.

3.10 Appropriate Technology

Appropriate technology is held to be the systematic application of technical knowledge and devices to the solution of salient health problems which do not set off negative effects on the society, the economy, the culture or the ecology in which it is applied. The population must find the technology viable, acceptable and easily manageable; and, the technology itself must be efficient, efficacious and effective in attaining the objectives and solving the problems.

Many technologies specifically for community health education are mentioned in the section on "Methods and Techniques." The most important point in the development of these technologies is to involve the community in this process, and to make the most of the resources, culture, and viewpoints of the population itself. It also has to be recognized that the only way to bring about real changes in health behavior is to clarify values and attitudes. If the aim is to foster in the community an attitude of responsibility for its own health, then the technologies of community health education must promote this approach.

Community health education must also adjust technologies developed for programs of other sectors and work with the community so as to draw on the resources available in it and to ensure that what is introduced is understood by the local population and can be used in dealing with their problems.

3.11 Technical Cooperation among Countries

The purpose of technical cooperation among countries is to develop their national capabilities and mobilize them to the utmost through financial an technical exchanges.

This cooperation between countries has a multiplier effect. It must be based on an understanding of the kind of cooperation the country needs and on its own capacity to meet this kind of need. Technical cooperation among countries complements the national effort, and must take account not only of technical and financial cooperation between developed and developing countries, but also among developing countries themselves.

To extract the greatest benefit from this cooperation, a country must develop to the utmost its capability for the analysis and programming of the internal cooperation it needs.

To promote technical cooperation among the countries of the Region, intercountry agreements must be concluded at the political and technical levels. National policies for technical cooperation between developing countries in the health field must incorporate the viewpoints of the public and private sectors, and adequate links must be forged with other governmental sectors to ensure that a comprehensive multisectoral approach is developed.

Mutual assistance between developing countries must also include the dissemination of technical knowledge and means for the training of health professionals, the development and exchanges of appropriate technologies, and the sharing of experiences and information on factors and activities in projects that have been successful.

This can be achieved by establishing national and subregional training centers that emphasize community participation, and community health education as a means to achieve it, and at which personnel from other countries may study methods and techniques that have been successful and those that have contributed to failures.

There is a need for a good information system that affords effective communication between different governmental sectors, that will help to build up a knowledge base, and that will provide sufficient information for exchanges of experiences among the countries. At the national level, a system is required for providing data on the country's present situation and future needs, while in the field of community health education information will be needed concerning: a) personnel and training required; b) techniques in use and needed; c) learning and reference materials, and evaluations thereof, and d) models, descriptions, and evaluations of methods and techniques that have been effective in promoting community participation through community health education activities.

3.12 Role of the International Agencies

On the basis of the countries' own programming, the international agencies must support the development and implementation of international strategies, programs, and technologies through technical and financial cooperation and by supporting intercountry exchanges of community health education experts and the use of national and subregional training and research centers.

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XXXIII World Health Assembly, May 1980.

ANNEX I

LIST OF PARTICIPATING COUNTRIES

(23 countries)

(in alphabetical order)

Antigua
Argentina
Barbados
Bolivia
Brazil
Chile
Colombia
Costa Rica
Cuba
Dominica
Ecuador
Guatemala
Honduras
Jamaica
Mexico
Panama
Paraguay
Peru
St. Kitts-Nevis
St. Vincent
United States of America
Uruguay
Venezuela

ANNEX II

SUMMARY OF THE FINDINGS OF THE STUDY IN 23 COUNTRIES

1. Community health education policy or doctrine:

A policy or doctrine exists	14 countries
The doctrine is implicit	1 country
The doctrine is in preparation	2 countries
No data	6 countries
	23 countries

2. Dissemination of the community health education or doctrine:

Widely disseminated	11 countries
Disseminated to some extent	2 countries
Implicit	1 country
No data	9 countries
	23 countries

3. Existence of national programs with community health education services:

National programs exist	18 countries
National programs do not exist	3 countries
No specific unit exists	1 country
No data	1 country
	23 countries

4. Agencies which have national programs with community health education services:

Ministry of health	11 countries
Ministries of health, education and agriculture	2 countries
Ministries of health and education and various organizations	9 countries
No data	1 country
	23 countries

5. Coordination with other governmental sectors and agencies:

With ministry of education	4 countries
With ministries of education and agriculture	9 countries
National coordinating agency	3 countries
No intersectorial coordination exists	3 countries
No data	4 countries
	23 countries

6. Existence of standards and their circulation:

Standards exist and are circulated	8 countries
Standards exist and are circulated to a limited extent	2 countries
Standards exist but are not circulated	3 countries
No standards exist	4 countries
No data	2 countries
	19 countries

7. Personnel training in health education:

Trained in formal academic courses	4 countries
Professional staff trained in academic courses, other staff in short courses or in-service training	10 countries
In-service training only	4 countries
Incorporated into content of other training	2 countries
No training programs	2 countries
No data	1 country
	23 countries

8. Trend/approach of community health education:

To involve and commit the community	8 countries
To improve health	6 countries
Service-community relations	3 countries
Not specified	4 countries
To raise level of health and welfare	1 country
To complement nutrition and education	1 country
	23 countries

FACTORS IDENTIFIED BY PARTICIPATING COUNTRIES AS INFLUENCING COMMUNITY HEALTH EDUCATION

Contributing factors

1. Health sector personnel

- Continuity of the health agent and program
- Systematic supervision
- Interest in the program
- Training
- Creative leadership
- Cooperation within the health team
- Knowledge of the local problem

2. Technology

- Standards circulated and understood
- Mass dissemination of information
- Avoidance of conflicts between technologies and messages, and community tradition
- An effective, cognitive educational approach
- Exchanges of experience between communities
- Formation of community groups and health committees
- Tangible benefits deriving from the program
- Involvement of community leaders

Inhibiting Factors

1. Health sector personnel

- Personality conflicts
- Frequent personnel turnover
- Inadequate communication between levels of personnel
- Lack of motivation
- Lack of cohesion within the health team
- Difficulties of supervision
- Lack of training
- Resistance to new methods

2. Technology

- Failure of health sector personnel to perceive the benefits of working in small groups and with community organization
- The traditional curative approach
- Reluctance to delegate authority
- Lack of programming based on prior diagnosis so as to make better use of the resources
- Failure to integrate the intermediate and auxiliary personnel into the education program
- Physical, cultural and economic inaccessibility of the institutional system
- Isolation of education activities from the program
- Insufficient coordination of multisectoral programs

3. Resources	3. Resources
Availability of requisite resources	Lack of financing
Technical and financial cooperation of international agencies	Lack of audiovisual and learning materials
Inclusion of the education sector	Delayed delivery of materials
Intersectorial cooperation	Ignorance of the potential for community participation
	Insufficient transportation
	Desertion of personnel from the programs
	Duplication of effort
	Lack of local, national and international training programs and of funds for training abroad
	Lack of personnel trained in health education
4. Official support	4. Official support
Existence of a clear-cut policy in support of community health education	Tendency to government paternalism and community dependence
Interest and support of government officials	Lack of support from officials
Adequate infrastructure for implementation of education activities	Obstacles in the bureaucratic structure
Administrative decentralization resulting in improved intersectorial integration	An atmosphere of electioneering and partisan rivalry
	Lack of a government policy in support of educational activities
	Difficulty in identifying community leaders because of the political character of the program
5. The community	5. The community
Training of community volunteers	Dispersal of the rural population and rapid growth of marginal urban areas
Employment of community representatives in health programs	Absence of felt needs in health
Utilization of resources available in the community	Initial community resistance
Cooperation among members of the community	Existence of deeply rooted beliefs and practices
	Volunteer auxiliaries who identify more with the health system than with the community

EVALUATION

Evaluation of the community health education process must be preceded by an analysis of four components:

(a) Characteristics of the participants in the program;
(b) Characteristics of the administrators of the program;
(c) Characteristics or attributes of the program;
(d) Nature of the relationship (interaction) among the participants.

***

(a) Characteristics of the participants in the program;

The object is to ascertain and assess changes brought about in their knowledge, attitudes and behavior, such as the emergence of appropriate approaches to the solution of problems, the improvement of cohesion among individuals and groups, the launching of new forms of cooperation, the mounting aspirations of the participants, and the emergence of a public opinion open to communication.

(b) Characteristics of the administrators of the program;

The personnel of the health programs will have to change or modify their relations with the community. Their organization must be flexible enough to deliver the services the population needs under prevailing conditions. The changes that have come about and their function will be evaluated, as will the dynamics of interpersonal relations among the health service personnel and the establishment of coordination and support relationships of an intersectorial nature. The limitations of the health organization must be acknowledged frankly, instead of looking for the causes of all problems in the community. In addition, health administrators must realize that they can and should take on a more active commitment in response to their perception of the community's problems and aspirations.

(c) Characteristics or attributes of the program;

To what extent is the program, or the program activities, seen as relevant to the community's problems? Are there behavior patterns in the population that run counter to the program's procedures? It must be determined to what extent the program has adjusted to the community's characteristics and needs, or whether the tendency has been to carry out the

activities within a rigid and conventional frame of reference. With an understanding of the attributes of the program, possible secondary or undesirable effects can be averted and the durability of the changes assessed.

(d) Nature of the relationship (interaction) among the participants

Study of the nature of the relationships established between the community and the health team could help to explain the outcome of this interaction and provide guidelines for replicating conditions that have proved favorable to the progress of the program. It could also show how to avoid those blunders of inexperience in both the community and the service personnel that have raised barriers or obstacles to that progress.

The evaluation cannot be based solely on quantitative data, but must rely as well on objective and qualitative data, to which end there must be a constant search for opinions, ideas, periodic records of situations and their outcomes, the analysis of processes of conflict and the study of interpersonal relations.

Technical Discussions

Washington, D.C.
September 1980

Provisional Agenda Item 20

CD27/DT/2 (Eng.)
25 September 1980
ORIGINAL: ENGLISH

OVERVIEW AND CENTRAL OBJECTIVES OF THE TECHNICAL DISCUSSIONS ON

"COMMUNITY HEALTH EDUCATION: EVALUATION OF PRESENT PROGRAMS, NEW APPROACHES AND STRATEGIES"

OVERVIEW AND CENTRAL OBJECTIVES OF THE TECHNICAL DISCUSSIONS ON

"COMMUNITY HEALTH EDUCATION: EVALUATION OF PRESENT PROGRAMS, NEW APPROACHES AND STRATEGIES"

The Thirtieth World Health Assembly declared in Resolution W.H.A. 30.43 that "Health for All by the Year 2000" is the most important social goal for the Member Governments in the coming decades, in order to achieve a level of health that will permit the citizens of the world to lead socially and economically productive lives. Among the basic strategies needed to reach this goal are primary health care, intersectoral articulation, and community participation. Health Education is an extremely important and integral part of these strategies, and is essential for the promotion of primary health care goals and priorities.

Countries in the Region of the Americas are currently developing specific national strategies to meet the goal of health for all by the year 2000. Community participation in health and development, through the means of community health education, will be of prime importance in the successful development and implementation of these strategies.

The "reference" document prepared as background for the Technical Discussions gives a brief overview of community health education activities being conducted in the countries and indicates suggestions for future approaches and strategies in this field. Through an exchange of experiences and views during the Technical Discussions, it is hoped that the participants will develop some recommendations concerning community health education and community participation in health and community development programs.

The principal objective of the Discussions is to consider new approaches and strategies in community health education, in light of current experiences. It is suggested that this analysis focus on the following main points:

1. Clarify the role community health education should play in encouraging positive health behaviors and active community participation in health promoting activities. More specifically. it will be important to identify critical health areas in which community participation is essential, and to what extent and in which ways community health education can be most effective in promoting this participation.

2. Examine the most important factors which affect individual, family and community behaviors in health and development. Consideration should be given on three levels:

- the participant in primary and self-care efforts and the utilizer of health services: how to best identify the priorities and motivations of this population; what are the critical areas of health in which community action can achieve significant improvements.

- the technical and administrative health personnel: how to better understand the needs of the community and adapt health services accordingly; what is the best way to develop health programs and activities within the social, economic and cultural constraints of the community.

- the policy and decision makers: how to best integrate health programs and community health education activities into the development of national programs and plans; what are the basic requirements and conditions needed in order to effectively implement community health education activities including policies, human and material resources, technical support, basic data and information, etc.

3. Discuss ways in which community health education can promote community input into the design, implementation and evaluation of health and development programs. How can programs be coordinated nationally to maximize available national and local resources and minimize duplication of efforts?

4. Identify priority areas in which community health education efforts in the countries should be strengthened in order to make health and development programs more effective. What will be required over the next five to ten years to help community health education more widely promote primary health care activities.

Technical Discussions

Washington, D.C.
September 1980

Agenda Item 20

CD27/DT/3 (Eng.)
26 September 1980
ORIGINAL: ENGLISH

TECHNICAL DISCUSSIONS: "COMMUNITY HEALTH EDUCATION: EVALUATION OF PRESENT PROGRAMS, NEW APPROACHES, AND STRATEGIES"

Final Report

The Technical Discussions of the XXVII Meeting of the Directing Council of the Pan American Health Organization, XXXII Meeting of the Regional Committee of the World Health Organization for the Americas, were held on 26-27 September 1980 in the Headquarters of the Organization in Washington, D.C., and dealt with the topic "Community Health Education: Evaluation of Present Programs, New Approaches, and Strategies".

At its session on 24 September 1980, the XXVII Meeting of the Directing Council elected Dr. Carmelo Calvosa Chacón (Costa Rica) Moderator for the Technical Discussions and Ms. Veta Brown (Bahamas) General Rapporteur. The Director of the Pan American Sanitary Bureau appointed Ms. Marilyn Rice as Technical Secretary.

At the initial plenary session, Dr. George M. Foster presented a paper relating community health education to community participation from the community's view point. Ms. Marilyn Rice summarized the working Document CD27/DT/1 and introduced the theme and the mechanics for the Technical Discussions.

The participants were divided into two Working Groups, the officers of which were elected as follows:

Group I

Moderator:	Dr. Merlin Fernández (Honduras)
Rapporteur:	Dr. Jaime Solórzano Espinoza (Guatemala)
Technical Secretaries:	Dr. Isabel Rojas Aleta (PAHO)
	Dr. Héctor García Manzanedo (PAHO)

Group II

Moderator:	Dr. Germán Jiménez Bozo (Colombia)
Rapporteur:	Dr. Mariano García Viveros (Mexico)
Technical Secretaries:	Dr. George M. Foster (PAHO)
	Dr. Felipe García Sánchez (PAHO)

There was agreement in both Groups that the working document was comprehensive, stimulating and relevant for the Technical Discussions. The major issues in the suggested discussion guide were covered in the deliberations. Views expressed in each Working Group were summarized by their respective officers and consolidated into the following conclusions:

Diagnosis of Community Characteristics

Participants expressed a need for new mechanisms which will allow for community identification of its own needs, priorities and socio-cultural characteristics. The information thus obtained should serve as the basis for planning and implementing health programs. Through this diagnostic process, the community will become involved in clarifying its health beliefs and needs, which in turn will determine its health behaviors. This process should allow for modification of health priorities in line with changes in individual, family and community perceptions.

Promotion of Community Input

Most of the current health personnel and health education approaches regard the community as passive recipients of health messages. New methodologies must be developed and utilized which will promote individual, family and community self-reliance. This thrust to health education must actively involved individuals in the learning process and in changing health behaviors and conditions.

The following were some suggested means to conduct participatory health education activities:

a) utilize the community's resources and characteristics to develop educational methodologies appropriate to local conditions, while maximizing potentials for collective health activities;

b) identify influential individuals in the community who can help to develop committees and groups for promoting health projects;

c) clearly define the types of responsibilities and obligations community members will be expected to share with health personnel; and

d) select the most appropriate educational methodologies for the target population, such as child-to-child approach, parent-child teams, play groups, volunteer groups and service groups.

Administration

Programs should be delivered in line with goals established jointly by the community and health professionals within the limits of the available financial and manpower resources.

Measurable educational goals and attainable standards must be established.

Cognizance must be taken of the country's political structure, and health education must be viewed in the more comprehensive scope of community development. Successful community development programs will be facilitated by establishing a multisectoral unit charged with the responsibility of administrating and managing the integration of programs under the auspices of a government agency.

This type of collaboration will allow the government, the private sectors and the community to be represented at all levels of planning, implementation and evaluation of programs. It will also ensure program continuity.

Health Education Training

It was generally accepted that each member of the health team is an educator and that the community is the target of these efforts, as well as being members of the health team.

Training should therefore be provided to three levels of personnel:

a) Professional health educators;
b) Health team members - professionals and paraprofessionals; and
c) Community workers.

In light of previous factors which rendered traditional practices of health education personnel less effective, the need to introduce new dimensions early in their training programs was stressed.

It is necessary for health professionals to receive training in the following areas: a) community and interpersonal dynamics, b) participatory approaches to community work, c) effective teaching methodologies, and d) instruments to conduct simple social research.

Influential community members should be oriented in motivational techniques and group dynamics. This training will help in stimulating community participation in health programs.

Technical Cooperation Among Countries

The Group recommended the sharing of methodologies, information and experiences on community health education activities among different countries.

Information systems must be established to facilitate the collection of data about effective programs.

Role of International Organizations

The role of international organizations in community health education should be to support the development of effective health education activities, materials and models. Through international organizations, programs between countries can be developed, facilitated and improved.

Evaluation

The importance of periodic evaluation of health activities was stressed.

Evaluation of health education activities will give insight into what is effective in attaining program goals and objectives. Effective activities can thereby be replicated and continued, and ineffective or problematic approaches can be changed.

Periodic evaluation will also signal, on a regular basis, what new program inputs will be needed, such as training, materials and personnel. The establishment of an information system, linking local, regional and national health activities, is essential in order to provide regular feedback on program progress and needs.

Research

Although is often thought of as something sophisticated and very costly, simple studies can be carried out to measure the efficacy of new methodologies and appropriate technologies. Additionally, it was recommended that operational research be conducted to increase understanding in the following areas:

a) The effect of human motivation and social dynamics on cooperation and group participation,

b) Types of barriers that inhibit changes in attitudes and behavior patterns, and

c) Factors that determine individual and group priorities.

The findings of these studies will greatly enhance the efficacy of health education programs and indicate crucial areas for training of all individuals conducting health education activities.