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ABSTRACT

This consultation was seen as a part of a process to encourage member states of the World Health Organization to redefine the role of health education in relation to health promotion and to improve their health education policies and practices as tools for health promotion. Reviews are presented of three papers: (1) "A Conceptual Analysis of Major Developments Concerning the Structure and Functions of Health Education" (Keith Tones); (2) "A Review of Major International Developments Concerning Health Education in Europe" (John K. Davies); and (3) "A Proposed Model of Good Practice for Health Education" (Hans Hagendoorn). The papers themselves are annexed to this booklet. References for each paper are included. (JD)

EDUCATION FOR HEALTH IN EUROPE

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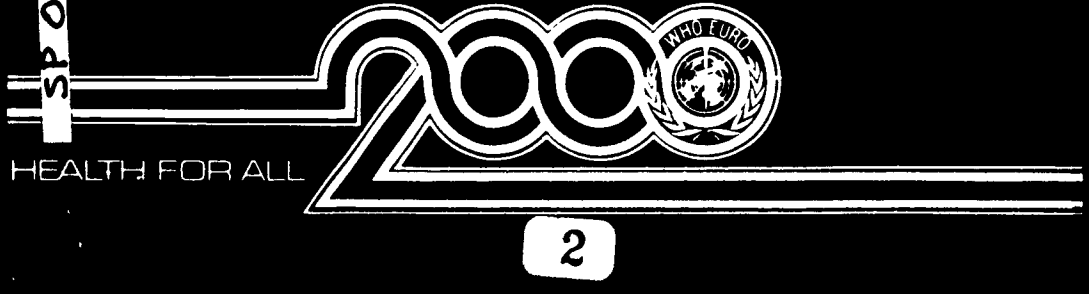

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HEALTH FOR ALL 2000

Note

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CONTENTS

PREFACE

The Thirtieth World Health Assembly resolved in May 1977 that "the main social target of governments and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life". The Alma-Ata Declaration in 1978 endorsed education as fundamental to the attainment of the goal of health for all. In 1980, the Regional Committee for Europe accepted the regional strategy for attaining the goal of health for all by the year 2000, and the Regional Office embarked on a major effort to put this strategy into operation by developing regional targets.

The discussion document on *Concepts and Principles of Health Promotion* was published by the Regional Office in July 1984. This gave a new focus and direction to health promotion. It also presented an opportunity to health education to function more effectively, within the context of health promotion, towards the goal of health for all. In November 1986 the International Conference on Health Promotion produced the Ottawa Charter.

The Consultation endorses the unifying concept of health promotion as illustrated in the Ottawa Charter. It affirms that education is a vital process in attainment of the strategy for health for all, few of whose targets could be attained in the absence of any educational input. In particular, it agrees that, by 1990, education programmes in all member states should enhance the knowledge, motivation and skills of people to acquire and maintain good health. Member states have accepted that, to attain this target, adequate organisation and funding should be ensured for education for health at all levels. Not all member states have yet set up adequate organisational infrastructures for education for health.

A small core group will be established by WHO to take this work further. It will be linked to the work plans of the WHO collaborating centres for health education. Support and advice will be called on from selected experts and organisations such as the International Union for Health Education. The main work of this core group will be a systematic analysis of health education models, policies and organisations in operation in Europe; an investigation of how and to what extent they contribute to attainment of the targets for health for all; and the identification, from the results of this work, of examples of good practice (including effective criteria) to assist member states in developing appropriate, co-ordinated infrastructures for their education for health programmes.

Health promotion is creating the context and the environment in which the many sectors and disciplines in society can contribute towards health for all in a planned, co-ordinated and supportive manner. Health education has a major role to provide people, particular groups in particular locations, e.g. schools and workplaces, with the knowledge, motivation and skills to acquire and maintain health and to enable them to contribute to the promotion and development of a health supportive environment.

This consultation is seen as a part of a process to encourage member states to redefine the role of health education in relation to health promotion and to improve their health education policies and practices as tools for health promotion.

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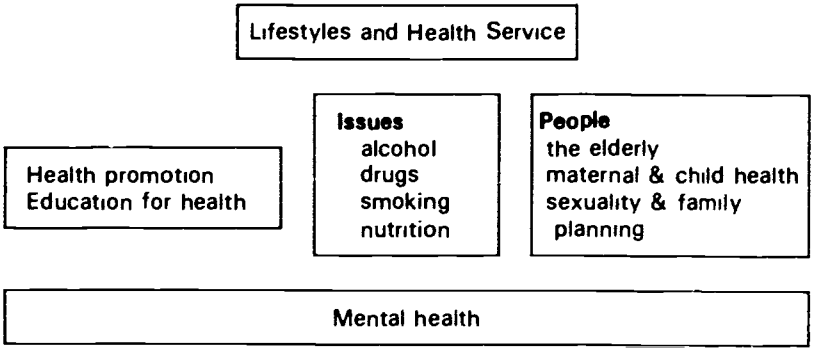
Setting the Context for Education for Health in the Light of the WHO Health Promotion Strategy

Dr Kickbusch welcomed delegates on behalf of the Regional Director. She explained that in 1985 the European Office had been restructured to correspond with the main sections of the target document. Earlier this year the service for Lifestyles and Health was created to encompass a number of programme groupings (Fig. 1).

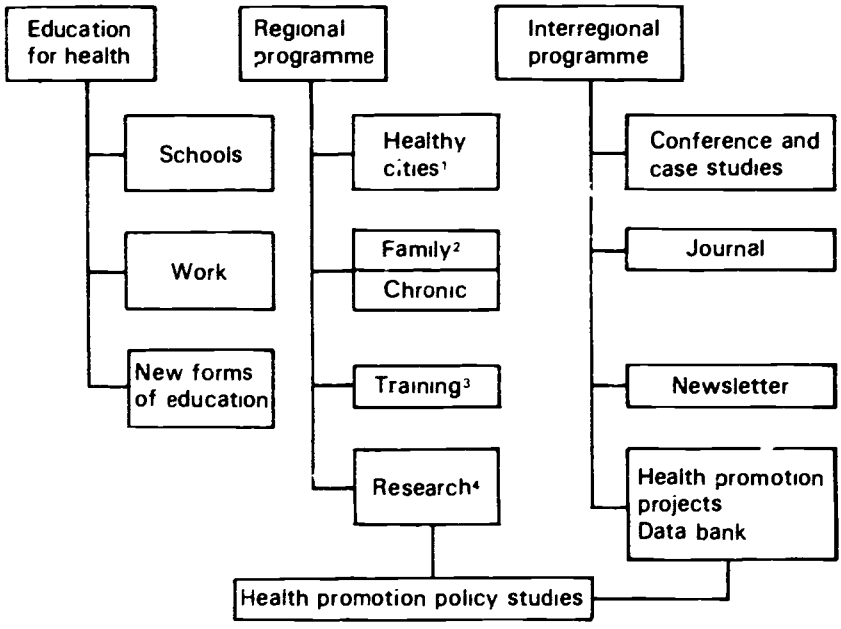
Fig. 1—The Lifestyles and Health Service (WHO EURO)



WHO planning for the period 1990-1991 would move from programmes to achieve regional targets and this would be reflected in budget allocations. The majority of the work on education for health would appear under Target 15 (Knowledge and Motivation for Healthy Behaviour), but would also be referred to under Targets 1 and 2 (Equity in Health and Adding Life to Years). A horizontal, not vertical, strategy would be the key to attaining these targets. To assist this process a meeting of all collaborating centres in the service would be held in spring 1988. The role of the collaborating centre was crucial. A combined information base on lifestyle trends in Europe was required. The Regional Office was currently reviewing the target document to bring it up to date and responsive to the current needs of the Region. Target 13 (Healthy Public Policy) included work on the development of the Adelaide Conference on Health Promotion to be held from 5-10 April 1988. Inter-programme collaboration was stressed by Dr Kickbusch. Education for health was included within the contextual umbrella of health promotion. The organisational changes in the European Office reflected the changing role

and increased importance of health promotion. Figure 2 indicates this change and shows the place of education for health.

Fig. 2—The changing role and increased importance of health promotion



[1] Application programme.
[2] With primary health care
[3] Linked to healthy cities.
[4] Indicators and publications

Target 15 was to be attained by 1990. There was a need therefore to review and analyse the infrastructures existing for education for health in Europe. Dr Kickbusch gave an overview of recent developments in the health promotion programme, including "Healthy Cities", health promotion and chronic illness in the family (Cologne), health promotion training (Granada and Gothenburg), health promotion research network (including research into lifestyles and health promotion indicators) and the inter-regional programme (Ottawa, Adelaide, health promotion journal and newsletter). Two trends were highlighted: the movement towards health promotion policies at regional and national levels, and the growth of interest in health promotion and public health at local level. These trends should be considered when reviewing infrastructures.

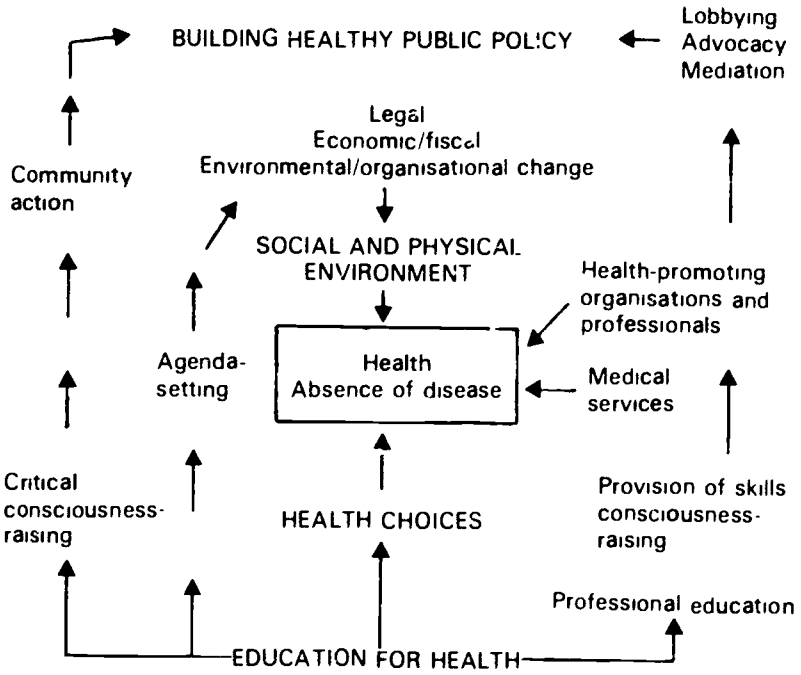
Dr Hagendoorn was elected Chairman and Mr Davies, Rapporteur.

The Chairman referred participants to the scope and purpose document for the meeting. He highlighted that this consultation was the first step in the process of appraising the role of education for health in health promotion and in producing a plan for the production of models of good practice.

A Conceptual Analysis of Major Developments concerning the Structure and Functions of Health Education: Dr Keith Tones

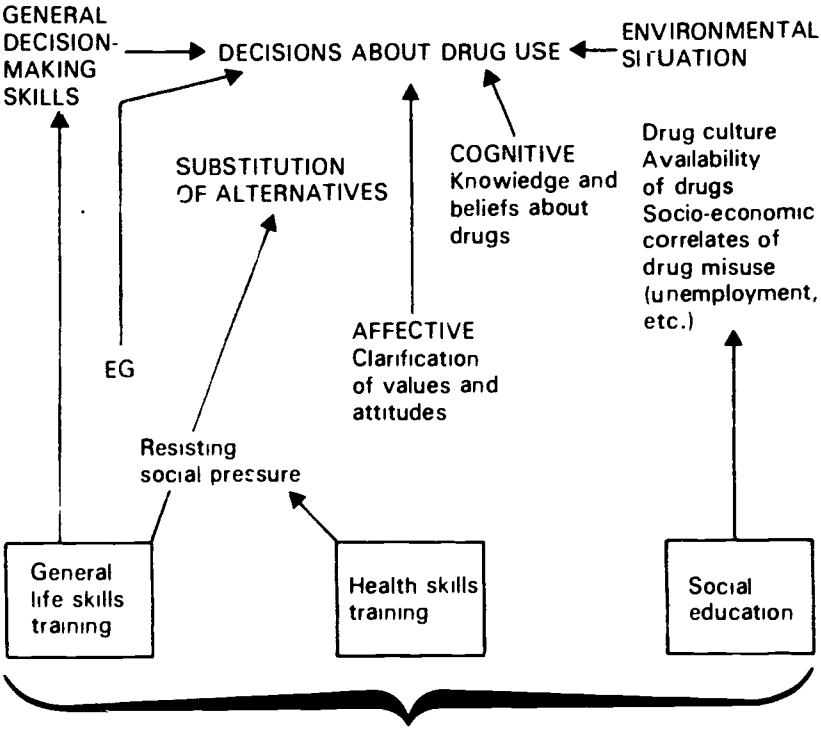
The purpose of Dr Tones' paper was to give a general overview of the major role of education in health promotion strategies. He examined different approaches to health education and the process of education and self-empowerment. The implications of the empowerment goal were highlighted using educational systems and community development approaches as examples. In Figure 3, Dr Tones demonstrated how the new public health concept could be attained by the health choices people make and by building healthy public policy.

Fig. 3—The contribution of education to health promotion



Recent changes in health education theory and practice were identified: (a) health education should be concerned less with the prevention of specific diseases and more with fostering a holistic approach; (b) health education should be concerned more with providing support; (c) the goal of health education should be concerned less with promoting compliance and should foster negotiation and collaboration with medical practitioners within the WHO broad based approach to health, who will deliver health skills training; for example in schools, in primary health care and in the workplace. Dr Tones focused on drug education to illustrate life skills teaching as part of a general self-empowerment approach (see Fig. 4).

Fig. 4—A broadly based approach to the prevention of drug misuse



A second example of a non-specific self-empowerment strategy was community development. Dr Tones saw this approach as a means of empowering communities. He referred finally to the role of the mass media and its agenda-setting function.

A Review of Major International Developments concerning Health Education in Europe: John K. Davies

This review was selective from the WHO's viewpoint, and therefore did not include all the activities of other governmental or non-governmental international agencies. From the outset at WHO global level, the development of health education was traced through a series of meetings and activities within the European Region of WHO. These included: the place of health education in the health administration of various countries, where it was recommended that it was not possible to produce a "best model". Participants at this working group stated that health education "must be organised to fit the value system, organisational structure and health problems of each country in the region".[1] The Dresden working group in 1977 had tried to identify common standards of practice to strengthen health education in the region.[2] They produced the following "principles" of health education:

the community as a whole must take responsibility for health education;

health education should be organised in an efficient and planned fashion;

health education should be founded on a scientific basis and its methods should be scientifically tested and evaluated; to achieve this, research into health-related behaviour is required;

health education should activate the population to protect its health and enhance personal responsibility for health;

there is a special role for medicine and the health service in health education;

health education should be differentiated and oriented according to target group.

It was recommended at the time that governments should consider the above principles when planning, organising and directing health education. Mr Davies examined in depth the adoption of the strategy for health for all, the Alma-Ata Declaration and the growth of a new health education programme by the Regional Office. He pointed out that education was recognised as fundamental to the attainment of the goal of health for all.

The Alma-Ata Conference on Primary Health Care[3] identified health education as the first of eight essential components of primary health care. The new approaches developed by WHO included the following basic orientations for health education: it should work with new images and a positive concept of health; make use of innovative educational approaches; choose a multi-sectoral, multi-disciplinary approach; be

geared towards lay participation and community action; and develop new strategies at all levels of action (government, professional and community).

The Council of Europe began a series of reviews of health education and prevention during the period 1978-1981. The recommendations from these studies were reviewed. The three main thrusts of the Sixth General Programme of Work of WHO (health promotion, education for prevention and supportive health education) were widened to include lifestyle aspects. The importance of the social environment and the role of individual responsibility in contributing to community participation in health was stressed. A series of meetings to further develop the lifestyles and health concept was referred to. Attempts were made to review recent developments in the growth of the health promotion concept in WHO and identify the role of educational interventions. Education was acknowledged as a basic precondition for health in the Ottawa Charter.* Inter-relationships between health education and health promotion were discussed and attempts made to clarify them.

Recent reviews by the WHO European Advisory Committee on Health Research were referred to. It was concluded that health education is and will remain an important core aspect of health promotion.

Some participants recommended that it would be extremely valuable if the past work of the International Union for Health Education could be included in this review.

A Proposed Model of Good Practice for Health Education: Dr Hans Hagendoorn

After reviewing his personal experiences in the field of health education, Dr Hagendoorn concluded that health education can only be successful in a context broader than health care alone, and it needs a solid structure. He saw the idea of health promotion helping this process by setting health education in the appropriate context. On examining the Dutch situation, he acknowledged that it is different from other countries. The following important elements should be included in a good model of health education practice: continuity in governmental and institutional policy, stable financing, trained experts to support the work, documentation and compilation of knowledge, training and education, development of methods, research and an overview of activities.

Referring to the role of the International Union for Health Education (IUHE) he put forward a matrix structure to improve the quality of health education practice. WHO could create the political context for health education. The growth of an integrated system of collaborating

* Ottawa Health Promotion Charter, 21 November 1986

centres was of the utmost importance to the development of health education in Europe. Dr Hagendoorn made the following conclusions: health promotion offers an excellent context in which to develop health education; the quality of health education practice should be improved according to national prerequisites; the IUHE can help in improving the quality of health education practice at European level; and important work can be achieved through the framework of the WHO collaborating centres.

Two main areas were highlighted in the discussion following Dr Hagendoorn's paper: although most of the participants were from national health education institutes, their health education systems varied enormously; and the role of trained experts versus the need for all people to be responsible for health education.

Participants divided into three discussion groups to report back on the following areas: clarification of definitions (How is health education defined in the context of health promotion? Are health education and education for health the same?); principles of health care education; differences in infrastructures; and the core functions of health education.

Group 1 concluded that health education and health promotion cannot be separated. Health promotion was seen as the umbrella context for health education. They identified the following core functions: the need to build on research, develop strategies and methods, train people, evaluate and set priorities. These functions, it was felt, could be enhanced by continuity of policy, strategy and methods. Although flexibility should be included, e.g. in respect of the acquired immunodeficiency syndrome, the group recommended that increasing resources would be needed and that communication as a two-way process with the grass roots should be maintained.

Group 2 inquired why WHO was changing terms such as *health education* at the present time. They acknowledged that health educators had recognised the political aspects of their work for some time and had taken no action. They defined the concept of education as being linked to growth and making informed choices. The group recommended that we need a separate policy, legislation and support systems for health education in whatever context, whether at school, at the workplace or at home.

The way the health care delivery system was organised was seen to be important. They saw the necessity for a central agency of some form to stimulate and promote good health education practice. The central core functions are seen as training (skills, technology and methodology), research, problem-solving and monitoring.

Group 3 saw health promotion as the basis, but acknowledged that further work needed to be carried out to define where health education fitted into this framework. They saw education as the key element of the

Ottawa Charter. Education for health and health education had different meanings in various countries of the European Region, but this was further complicated by language and translation problems. Health promotion was a very political concept, whereas health education was a process of involving people in the diffusion of learning to promote health. The group felt that the principles underlying health education practice were similar to those underlying health promotion. Health education specialists were needed at national level, the group thought, so as to support education for health. They queried whether advocacy, lobbying and planning should not be included in the core functions of health education. More work should be stimulated to understand the unique contribution education processes can make in attaining the targets for health for all.

A small core group was established from the participants attending the Consultation. This group analysed the detailed reports from the discussion group and proposed a summary. This summary was discussed by all the participants and the following statement agreed as a formal conclusion in order to give direction for future work:

Summary

The Thirtieth World Health Assembly resolved in May 1977 that "the main social target of governments and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life". In 1978, the Alma-Ata Declaration endorsed education as fundamental to the attainment of the goal of health for all. In 1980, the Regional Committee for Europe accepted the regional strategy for attaining the goal of health for all by the year 2000, and the Regional Office embarked on a major effort to put this strategy into operation by developing regional targets.

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At the end of the Consultation, Mr Vilain gave a short presentation on the WHO European Action Plan on Tobacco and announced that there would be a smoking conference in Madrid in late 1988. Professor Modolo announced that a conference for southern Europe would be held in Perugia in May 1988 entitled "Environment and health. The role of health education".

In closing the meeting, Dr O'Byrne thanked the participants for attending and contributing to the discussions. He promised that the core group on organisational structures would begin their work as soon as possible. A first step in this process would be the publication of a booklet with the summary and prepared papers included. This publication would receive wide dissemination in Europe so as to give renewed emphasis to WHO's education for health programme.

References

1. *The place of health education in health administration* report on a WHO Working Group Copenhagen, WHO Regional Office for Europe, 1977 (document ICP/HED 003).
2. *Principles and methods of health education:* report on a WHO Working Group Copenhagen, WHO Regional Office for Europe, 1979 (EURO Reports and Studies, No. 11)
3. *Alma-Ata 1978 Primary health care.* report on an International Conference Geneva, World Health Organisation, 1978 ("Health For All" Series, No 1)

Annex 1

Promoting Health: the Contribution of Education

Paper presented at the WHO Consultation on Co-ordinated Infrastructure for Health Education, Copenhagen, 11-12 June 1987 by K. Tones

Education for health: its contribution to health promotion

The importance of health promotion, as both a unifying concept and a motivating force, has been generally acknowledged. Health promotion will be the main vehicle for attaining the 1977 World Health Assembly's target of health for all by the year 2000, especially via the principle of primary health care contained in the Declaration of Alma-Ata.[1] The key principles of health promotion have been enshrined in the Ottawa Charter,* and the meaning of the concept has been subjected to detailed scrutiny.[2-4] This paper will consider the ways in which health education may contribute to the overall goals of health promotion and will be based on the following assumptions about the most important features of this concept as elaborated in the various publications mentioned above.

Health promotion is concerned with mental, physical, and social well-being and the prevention of disease.

Health promotion is a unifying concept. It therefore includes any measure that promotes health or prevents disease or disability.

Health promotion acknowledges that health is not only a product of individual lifestyle and personal choice but is also influenced by the social and physical environment. It is therefore concerned with "building healthy public policy" and "creating supportive environments".*

Health promotion recognises the multi-factorial nature of the influences on health and thus emphasises the importance of inter-sectoral collaboration in achieving health for all by the year 2000.

Health promotion asserts the importance of lay involvement in the achievement of community health; people must take responsibility for their personal health and the health of the community. Health and medical services must be responsive to consumer needs. A major goal of health promotion is therefore to empower people so that they may take control of their lives, of their health and of their health services.

In parallel with its focus on lay involvement, health promotion is concerned with demedicalisation and with the "reorientation of health services".* This involves increase in client control, greater self-

* Ottawa Health Promotion Charter, 21 November 1986.

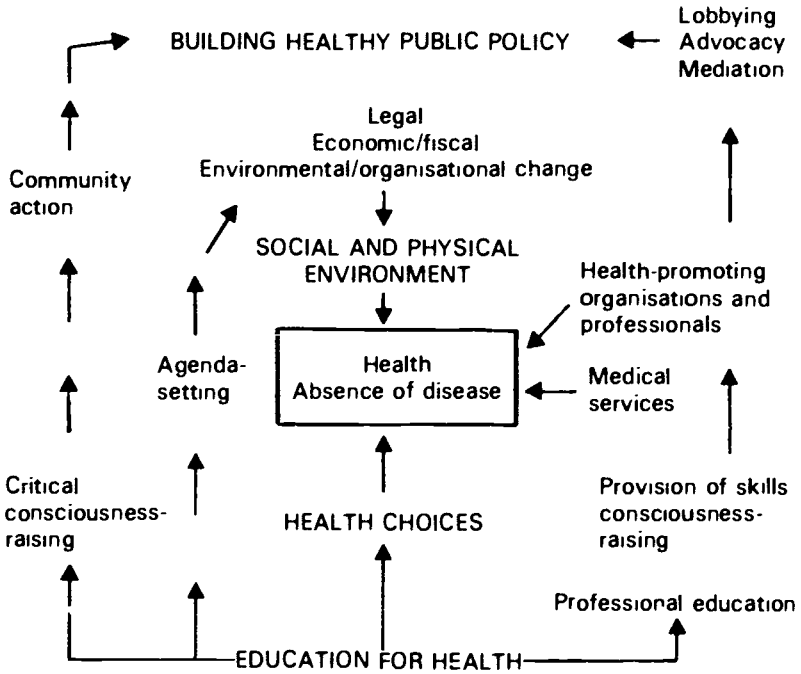
reliance, a move away from preoccupation with acute curative services towards primary health care, prevention and the pursuit of health.

The new public health concept, which is the target of health promotion, can be achieved by three major initiatives: influencing individual health choices; building healthy public policy in order to influence the social and physical environment, by using legal, fiscal/economic and environmental/organisational measures so that the healthy choice is the easy choice; and providing appropriate health and medical services. These initiatives have been discussed elsewhere,[5] as have their educational implications.[6] It is worth noting here, however, that health services will need to be interpreted in a broader way than before. They will now incorporate any public services having a part to play in health promotion, e.g. housing and transport. As has been noted in the Vienna dialogue on health policy and health promotion,[7] this broadening of the scope of health services poses difficulties in implementation. Again, the term *social and physical environment* is applicable at not only national or community level but also micro level and will thus be relevant for such organisations as hospitals, schools or workplaces. Furthermore, the three initiatives described above are interrelated. For instance, people will make health choices about not only their lifestyles but also how they will seek to influence and use their health services. It is also self-evident that economic and legal measures would typically be needed before any major reorientation in health services can take place. These influences and initiatives are summarised in Figure 1, along with an analysis of the contribution of education.

Approaches to health education

Like most other important areas of human endeavour, health education is characterised by dialectical dispute and debate. Its rationale frequently reflects those ideological differences, and various attempts have been made to produce typologies that seek to describe the various approaches to health education deriving from the different philosophies of theoreticians and practitioners.[6] For instance, it is generally agreed that the traditional approach to health education is subservient to the "medical model"[7] and thus focuses in a reductionist way on the individual. The main purpose of this approach is to prevent disease (at primary, secondary and tertiary levels) by persuading people to adopt lifestyles that would reduce the risk of contracting a disease and/or facilitate recovery. It will typically be accompanied by exhortation to use health or, rather, medical services appropriately. This approach is still a legitimate part of health promotion. However, as Kickbusch[8] has shown, WHO's perspective about the function of health education in general and the individually focused preventive approach in particular has changed in certain significant ways. While personal choice is still

Fig. 1—The contribution of education to health promotion



important, there has been a change of emphasis in the following important ways:

health education should be concerned less with the prevention of specific diseases and more with fostering a holistic approach, i.e. concerned more with the adoption of a generally healthy lifestyle (which would reduce the risk of several important diseases) and with the feelings of well-being that should accompany such a lifestyle;

health education should be concerned more with providing support: many people are motivated to make healthy choices but lack the skills or the post-decisional support necessary to maintain a new and healthier way of living;

health education should be concerned less with promoting compliance with medical advice and with persuading patients and clients to adopt a pattern of use consonant with medical "theories of illness": in other words, to present to the doctor only potentially serious and curable conditions while accommodating to or self-medicating "trivial" symptoms; the goal of health education should rather be to foster negotiation and collaboration with medical practitioners so that patients might be helped to make informed decisions.

Perhaps more significant is the criticism of health educators, who address themselves solely to the individual while ignoring the social and environmental determinants of health and illness. They are, with justification, accused of victim-blaming. This argument has been well rehearsed elsewhere[9-14] and will not be reiterated here. The implication for health education, however, is clear: its function should be to raise awareness in the community about health-damaging aspects of the environment and the social origins of disease. This critical consciousness-raising should ideally be followed by active community involvement in devising ways of exerting pressure on local or central government as part of a process of building healthy public policy.

At this point, it is worth noting a form of consciousness-raising that differs from the true radical form in that it is relatively acceptable to governments or those holding power—unlike the critical consciousness-raising that would almost, by definition, be politically unacceptable and threatening. By way of illustration, let us consider the Ottawa Charter's commitment to "...respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies...." The goal of truly radical health education would be to generate public outrage at the health divide between rich and poor. Such an activity would doubtless by resented by governments on the grounds that it would be ideologically unacceptable, would pose a threat to vested interests that supported the particular political party in power and would, additionally, cost an enormous amount of money to implement. Nevertheless, consider an awareness-raising campaign, using the mass media, about the benefit to dental health of fluoridation of public water supplies. In this latter case, the policy decision might be fully acceptable to governments, which none the less used the awareness-raising exercise to influence public opinion before introducing legislation that would inevitably curtail individual freedom and could thus prove to be electorally unpopular without the precursor of health education. Although these two situations represent two ends of the spectrum of awareness-raising, the term *agenda-setting* is preferred for the fluoridation example while *critical consciousness-raising* is reserved for the more radical example.

Lobbying, advocacy, mediation and professional education

As is apparent from Figure 1, the development of public policies conducive to health is influenced by three related processes: lobbying advocacy and mediation. Lobbying is considered to be any activity whereby a person or group seeks to influence others in power. On the one hand, advocacy implies that lobbying is being implemented on behalf of others who are themselves typically disadvantaged in some way. On the other hand, the notion of mediation suggests the need to achieve some

degree of compromise between the often conflicting health interests of different groups. Whether these processes are a part of health education is arguable. Since these are processes that deliberately seek to persuade those in power to institute or change policy and since health education is concerned with facilitating choice, it is probably better to treat these variations on lobbying as different kinds of activity. However, it is clear that it is the duty of health professionals, and of all personnel having a health promotion role, to persuade governments to adopt healthy policies. In the words of the Ottawa Charter, "Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health." For this reason, one of the many functions of health education is to raise the consciousness of professional groups and provide them with the knowledge and skills they need to modify their own professional practices and help them to lobby, advocate and mediate as part of their professional roles, both individually and collectively, i.e. as individuals or through their professional organisations.

Figure 1 represents the ways in which various social, structural and individual factors influence health. Health is represented in both its positive aspect and the complementary state of absence of disease. Figure 1 also shows how health education may influence professionals, as mentioned above, facilitate health choices and stimulate community action through the process of critical consciousness-raising. It is, of course, notoriously difficult to achieve these different goals: professionals are frequently resistant to change, there are many barriers that prevent people from making healthy choices, and stimulating community participation is a problematic process. In the face of these problems, it is essential that health educators have clear goals, understand the various stages involved in the process of education and, above all, seek to empower individuals and communities.

The process of education

The purpose of education is to promote learning. Health education is concerned with the promotion of learning that is related to health and illness. This may involve the acquisition of knowledge and understanding, it may involve changes in beliefs and attitudes, it may require the acquisition of skills, and it may or may not result in a change in behaviour. However, whatever kinds of learning may occur, it is considered here as axiomatic that the prime aim of education for health is to facilitate informed decision-making rather than achieve health-related changes through propaganda or other forms of coercion. Indeed, one of the major tasks for health education is to remove those barriers, personal or environmental, that inhibit genuine free choice. However, before considering how this might be achieved, it is important to remind ourselves of what is involved in the process of education.

At one time, health education was influenced by the so-called KAP formula, which argued that knowledge (K) would not in itself lead to the practice (P) of healthy habits, and an intermediate stage of attitude change (A) was therefore necessary. The formula is, of course, simplistic and unacceptable in its emphasis on manipulating people through the use of attitude-change strategies as opposed to the ethically desirable goal of facilitating informed and self-empowered choice. None the less, it draws attention to the fact that there are separately identifiable stages in the educational process. The first of these consists of the transmission of information and the promotion of understanding. This stage might most conveniently be termed *communication* and is an essential prerequisite for successful health education. Health communication may be viewed not merely as a separate stage but also as a separate activity, and public information services (most probably using the mass media) may be established. This kind of service may provide a basis for health-related decision-making. However, while information is necessary for making health choices, it is rarely sufficient. There is also an intrinsic danger in separating information from education. A government, for instance, may believe that it has offered people a genuine choice when it merely provides them with information. It may then believe that any failure of the people to adopt a healthy lifestyle, having apparently ignored the information provided, is due to fecklessness or stupidity. This is not only self-delusion but also an insidious form of victim-blaming. As Green[15] notes, WHO's Seventh General Programme of Work[16] "provides for a greater integration of health education and public information activities...in which information and education are seen as elements of the same continuum".

It need hardly be said that communication, as defined above, frequently fails. This phenomenon has been extensively documented in the literature on doctor/patient communication (for a recent, sophisticated example, see Tuckett *et al*[17]). It is therefore essential that communications are carefully constructed, that messages are pre-tested and that feedback is obtained from the client group.

The next stage in the education process may be labelled *motivation*. Health educators are clearly concerned that people should not only understand the issues but also feel it is important to take action to safeguard their health and the health of their community. However, the KAP formula, which invited health educators to look for effective attitude-change strategies such as deliberate choice of credible communicators and the selective use of fear appeal, is incompatible with the current move from "authoritarian health education to supportive health education".[8] Such persuasive strategies are incompatible with the principle of free and informed choice. This does not, of course, mean that health education should be content only to communicate. It means that it should seek to modify beliefs rather than attitudes. Following the

formulation of such theorists as Fishbein,[18] attitudes (i.e. the feeling of importance attached to any given course of health action) result from a complex of beliefs (i.e. the extent to which various circumstances or associations are accepted as true). A major goal for health education is therefore to ensure that people's health beliefs are congruent with the realities of health and illness so that people may make genuinely informed choices. This is not an easy task and cannot be achieved merely by the supply of information. As Tuckett *et al*[17] demonstrated, a significant proportion of patients failed to follow the advice provided by their doctors, not because they had misunderstood or forgotten the information but because they did not believe the advice. In other words, they are not committed to other doctors' recommendations because these were not compatible with the patients' "theories of illness" or the patients' beliefs about the difficulties involved in following those recommendations.

The clarification of beliefs and the values associated with those beliefs is therefore one of the principal functions of health education. It requires dialogue, not prescription; the perspective of the learner must be shared. The health educator must therefore empathise with and respect the client, and must have the group and inter-personal skills needed to achieve that goal.

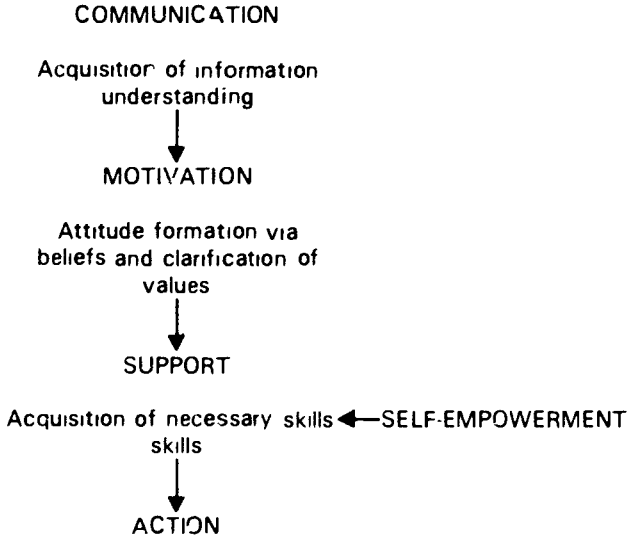
The final stage in the educational process is that of providing support. It is common for people to have understood the health message without being motivated to take action. It is equally common for people to have a positive attitude towards a particular health action and yet not translate that positive attitude into action. The reason for this is simple but often ignored: despite a high level of motivation, a person may lack the necessary skills to take action or may find the environment is not conducive to decision-making. A key task for health education in such circumstances is that of providing support. It is not difficult to supply the necessary skills, e.g. the skills needed to select and prepare healthy food or the social interaction skills involved in relating assertively to a doctor. It is much more difficult, however, to remove the environmental barriers that limit the freedom to make genuine, informed, healthy choices.

It is generally accepted that genuine freedom of choice is often illusory. A full discussion of this central issue in health education is beyond the scope of this paper and has already been explored.[19] In addition to the lack of personal skills referred to above, two major obstacles to healthy decision-making may be identified. These are the psychological barriers associated with feelings of personal powerlessness and the socioenvironmental barriers created by an oppressive, hostile or otherwise disadvantaging environment. To some extent, social barriers may be tackled by health educators seeking to mobilise social support (for instance, from family, friends and community groups), which may assist individual decision-making or maintain a person's resolve once the

healthy choice has been made. Removing structural barriers is probably not possible without a co-ordinated health promotion strategy. The restrictions imposed by low socioeconomic status, poverty, unemployment and other forms of disadvantage require the radical consciousness-raising efforts of health education if social policy is to be changed and the healthy choice made easier.

The psychological barrier is less apparent but no less problematic. It requires more than effective communication, the arousal of motivation and the provision of support. It requires a strategy of self-empowerment. The contribution of self-empowerment to the educational process discussed so far is shown in Figure 2.

Fig. 2—The process of education



Self-empowerment and health

At a common sense level, self-empowerment refers to a person's capacity to control his or her life. The degree of self-empowerment depends on the presence or absence of an aggregate of beliefs, values and skills. Self-efficacy is central to the motion of self-empowerment and was originally described by Rotter[20] in terms of locus of control. On the one hand, people who have a predominantly internal locus of control are inclined to believe that they are in charge of their lives. On the other hand, people who have an external locus of control tend to believe that their lives are influenced primarily by chance, fate or destiny and/or powerful

others. The ensuing feeling of powerlessness militates against healthy decision-making, since people do not believe they can have an effect on their level of health or on the personal and environmental factors damaging it.

The application of the notion of locus of control to the health field has been extensively researched.[21] External locus of control has been associated with sickness while "internality" has been correlated with nonsmoking, greater likelihood of contraceptive use, weight loss, seat-belt usage and inoculation against influenza.

Again, health education frequently invites people to defer present pleasure while offering them the prospect of some greater but future reward: a healthy or disease-free life. Clearly, then, those who value deferred gratification and have such a "future orientation" will be better suited to making health decisions. This tendancy is clearly related to the notion of internality. As Phares[22] puts it, "To attain control over one's environment, to achieve competence, or to reach positions of power and influence generally, all require that the individual eschew the lure of the present for the greater promise of the future."

A second value of great importance in fostering the capacity to make decisions is that of self-esteem. Self-esteem is associated with health in an obvious way. Apart from being, in its own right, an attribute of mental health, it makes sense to assume that people having little self-respect will not be motivated to look after themselves. Less obviously perhaps, people enjoying high self-esteem will be more likely to form their own opinions and have the courage of their convictions.[23] As Aronson & Mettee[24] show, people having high self-esteem will be more likely to experience high levels of dissonance when they act out of character, e.g. when they fail to take regular exercise while being persuaded that this measure would be beneficial to their health.

The final element in the cluster of characteristics associated with self-empowerment is composed of a repertoire of social and other life skills, such as relationship-building, time management and assertiveness. These skills have a dual function: they serve to enhance internality and self-esteem and they provide the tools that enable a person to take decisions, influence other people and generally have an impact on the environment.

Self-empowerment is acquired through socialisation and life experiences. The foundation is laid by primary socialisation and consolidated by secondary and anticipatory socialisation. The child who is reared to be autonomous and independent, who receives praise and is supported in achieving desired goals will manifestly be more self-empowered than one who receives a contrary socialisation. Self-empowerment will be further developed where the secondary socialising agency of the school confirms childhood experiences. Where a whole community is disadvantaged and offers a model of despair, the result will be apathy and "learned helplessness". It is small wonder that attempts to

break into the cycle of deprivation and empower communities and individuals have not met with ready success. It is also clear that health education cannot adopt a disease-specific approach; it cannot focus only on the provision of information and the development of beliefs and attitudes. Supportive health education must, above all, adopt a holistic empowerment approach, and this must involve a co-ordinated programme within the context of a yet broader strategy for health promotion.

Delivering health education: the importance of a co-ordinated approach

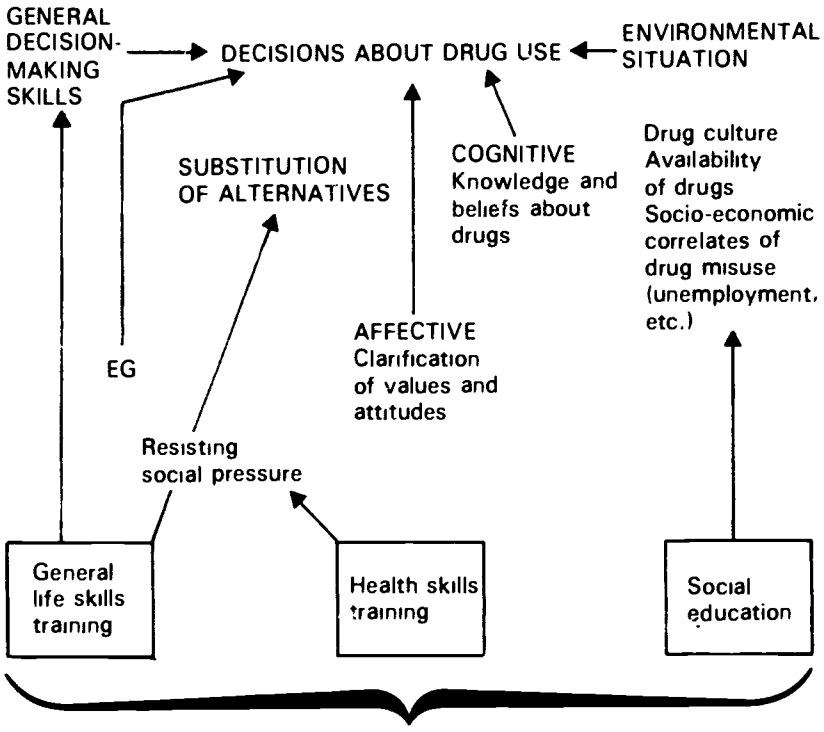
Given the magnitude of the task, health education must operate within a broad framework of health promotion, as indicated in Figure 1, if it is to be successful. Within that health promotion strategy, it is important that a community-wide approach is adopted. This means using a wide range of agencies; ideally, these would be co-ordinated by a specialist health education unit at district level and supported by a national service. Agencies of particular importance are the health and medical services, particularly primary health care; the schools and education system; the community, including workplaces, voluntary agencies, self-help groups and community health projects employing community development approaches. Two examples only will be provided here to illustrate the importance of broadly based health education approaches incorporating self-empowerment. The first of these is schools.

The importance of schools in delivering health education needs no justification here. Each country has its own system, its own mode of curricular organisation, its own way of incorporating health education. A detailed discussion of these issues is beyond the scope of this paper. Instead, one particular curriculum design for drug education will be used by way of example. Its purpose is to demonstrate how all curriculum topics and subject matter should contribute, directly or indirectly, to the prevention of a specific health problem. Central to this curriculum model (Fig. 3) is a programme of general personal and social education that incorporates life skills teaching as part of a general self-empowerment approach.

The promotion of personal and social development is a positive health goal in its own right. In the present context, however, personal and social education has two main functions. The first, that of social education, is to raise consciousness about important social and health issues. This is the critical consciousness-raising function described in Figure 1. These would include issues such as poverty and its association with ill-health. In the case of drug education, consciousness would be raised about, say, the drug-orientated nature of western society generally and the international problems of drug-trafficking. The second aspect of personal and social education concentrates on life skills teaching. This

aims at providing general empowering skills that will facilitate any decision-making (and again the self-empowered state could be seen as a positive health goal in its own right). However, specific life skills relating to the prevention of drug misuse would be incorporated (these specific skills may usefully be termed *health skills*). Therefore, whereas general life

Fig. 3—A broadly based approach to the prevention of drug misuse.



skills would among other things help a person to resist social pressure, the drug curriculum would aim at providing specific skills designed to help young people to resist the offer of a drug in, say, a social situation. Again, life skills training might provide an alternative substitute for drugs. For instance, skills in relating to the opposite sex, coping with authority and stress management should make cigarettes, which are typically used to deal with these personal and social situations, redundant. These matters are further explored in Tones.[25] The particular health teaching methods needed to teach health skills are described in detail by Anderson.[26]

The second example of a nonspecific, self-empowering strategy is that of community development. Community development has particular relevance for WHO's current concerns: as Feuerstein & Lovel [27] have pointed out, it provides a practically appropriate and philosophically sound strategy for the implementation of primary health care and is peculiarly relevant to problems of urban deprivation. It is also relevant in its requirement for a multisectoral approach to community problem-solving, and it is firmly rooted in its wholehearted commitment to community participation. The Vienna dialogue[7] points out the problems inherent in defining and stimulating community participation and lay involvement. Community development addresses just that problem in the context of seeking to empower neighbourhoods and their residents.

The central feature of true community development is its total commitment to promoting genuine self-empowered choice in communities using techniques of "non-formal education".[28] Many community initiatives, including some health projects, will pay lip service to self-empowerment and will employ many of the methods used in community development but will be uncommitted to the principle of self-determination. For instance, where change agents move into a community with a preset agenda of trying to persuade the community to adopt a series of medically approved preventive measures, they may be indulging in community organisation, but they are not involved in community development, even if they do seek out opinion leaders, use outreach techniques and keep a generally low profile.

A good flavour of the community development approach is provided by the Gulbenkian Foundation Working Party[29]: "We see community development as a main strategy for the attainment of social policy goals. It is concerned with the worth and dignity of people and the promotion of equal opportunity". The general approach adopted by community development workers in the process of empowerment can be summarised as follows: (1) the change agent, who should empathise with the community, will work with opinion leaders and seek to establish felt needs within the community; this will involve raising critical consciousness about important issues and problems, which may or may not include medically defined problems; (2) the change agent provides the community with the skills it needs to meet the needs it has defined and the problems it has encountered; (3) the change agent provides support for the actions initiated by the community while gradually withdrawing from a leadership role; and (4) the community achieves some degree of success, meets one of its felt needs and embarks on the process of self-empowerment. The process is described more fully by Batten[30] but more poetically in the oft-quoted Chinese poem[31]:

Go to the people
Live among them
Love them
Start with what they know
Build on what they have
But of the best leaders
When their task is accomplished
Their work is done
The people all remark
We have done it ourselves

What has been described above is a macro-analysis. However, when it comes to the detailed points when consciousness is raised and skills are provided, the basic health education methodology is not dissimilar to that used in schools or the doctor's surgery; it involves "counselling", group work and the provision of life skills through "structured group teaching",[27] role play and the like.

Conclusion

Nothing has been said so far about training and research. It is self-evident that research is essential if progress is to be made. It is equally apparent that training for all health promotion workers, educationists and lay people is an essential prerequisite for effectiveness. Very little has been included in this paper about the role of the mass media. This is partly due to a belief that the kinds of strategy referred to in detail are more important for providing the broadly based supportive education for health that we should now be seeking to develop. The mass media have an important part to play, especially as part of local community initiatives, professional education and the development of understanding through distance learning. Interestingly and paradoxically, one of the more powerful attributes of the mass media is often unavailable to health education. It is universally recognised that the mass media have a considerable potential for agenda-setting. They could therefore be used most effectively for health education's critical consciousness-raising function. However, since this function will frequently threaten vested commercial and political interests, access to the media may well be denied. This observation serves to remind us that political will and political cunning are essential weapons in the health educator's armamentarium!

References

1 *Report on the International Conference on Primary Health Care, Alma-Ata, 6-12 September 1978.* World Health Organisation, Geneva, 1978

2. *Health promotion, a discussion document on the concept and principles* WHO Regional Office for Europe, Copenhagen, 1984

3. Anderson, R. *Health promotion: an overview.* WHO Regional Office for Europe, Copenhagen, 1984.
4. Tones, B. K. Health promotion—a new panacea! *Journal of the Institute of Health Education*, **23**(1): 16-21 (1985).
5. Tones, B. K. Education and health promotion: new direction. *Journal of the Institute of Health Education*, **21**(4): 121-131 (1983).
6. Tones, B. K. Health education and the ideology of health promotion: a review of alternative strategies. *Health education research: theory and practice*, **1**(1): 3-12 (1986).
7. Vuori, H. The medical model and the objectives of health education. *International journal of health education*, **XXIII**(1): 1-8 (1980).
8. Kickbusch, I. Involvement in health: a social concept of health education. *International journal of health education*, **XXIV**(Suppl. 4) (1981).
9. Ryan, W. *Blaming the victim.* Pantheon Books, New York, 1971.
10. McKinlay, J. B. A case for refocusing upstream: the political economy of illness. *In:* Jaco, E. G., ed. *Patients, physicians and illness*, 3rd ed. Collier MacMillan, London, 1979.
11. Navarro, V. The underdevelopment of health of working America: causes, consequences, and possible solutions. *American journal of public health*, **66**: 538-547 (1976).
12. Draper, P. et al. Health and Wealth. Royal Society of Health Journal, **97**: 121-127 (1977).
13. Crawford, R. You are dangerous to your health: the ideology and politics of victim blaming. *International journal of health services*, **7**(4): 663-680 (1977).
14. Crawford, R. Healthism and the medicalisation of everyday life. *International journal of health services*, **10**(3): 365-388 (1980).
15. Green, L. W. *New policies for health education in primary health care.* World Health Organisation, Geneva, 1983.
16. *General programme of work (1984-1989).* World Health Organisation, Geneva, 1982.
17. Tuckett, D. et al. *Meetings between experts.* Tavistock, London, 1985.
18. Ajzen, I. & Fishbein, M. *Understanding attitudes and predicting social behaviour.* Prentice Hall, Engelwood Cliffs, New Jersey, 1980.
19. Tones, B. K. Health promotion, affective education and the personal-social development of young people. *In:* David, K. & Williams, T., ed. *Health education in schools.* Harper and Row, London, 1987.
20. Rotter, J. B. Generalised expectancies for internal versus external control of reinforcement. *Psychological monographs*, **80**(1) (1966).
21. Wallston, K. A. & Wallston, B. S., ed. Health locus of control. *Health education monographs*, **6**(2): 223-241 (1978).
22. Phares, J. E. *Locus of control in personality.* General Learning Press, Engelwood Cliffs, New Jersey, 1976.
23. Coopersmith, S. *The antecedents of self-esteem.* W. H. Freeman, Oxford, 1967.
24. Aronson, E. & Mettee, D. Dishonest behaviour as a function of different levels of self-esteem. *Journal of personal and social psychology*, 9: 121-127 (1968).
25. Tones, B. K. Preventing drug misuse: the case for breadth, balance and coherence. *Health education journal*, **45**(4): 197-203 (1986).
26. Anderson, J. Health skills: the power to choose. *Health education journal*, **45**(1): 19-24 (1986).
27 Feuerstein, M. T. & Lovel, H. Introduction: community development and the emergence of primary health care. *Community development journal*, **18**(2). 98-103 (1983).
28. Kindervatter, S. *Non-formal education as an empowering process.* Center for International Education, University of Massachusetts, Boston, 1979.
29 *A national centre for community development: report of a working party.* Gulbenkian Foundation, London, 1984.
30. Batten, T. R. *The non-directive approach in group and community work.* University Press, Oxford, 1967
31. Chabot, J. H. T. The Chinese system of health care. *Tropical geographical medicine*, **28**: 87-134 (1976).

Annex 2

A Review of International Developments concerning Health Education in Europe

Paper presented at the WHO Consultation on Co-ordinated Infrastructure for Health Education, Copenhagen, 11-12 June 1987 by John K. Davies

Introduction

It should be emphasised from the outset that this review is taken from the perspective of the World Health Organisation and its role in the development of health education in Europe. It does not attempt to review developments in individual countries of the European Region. Neither does it attempt to cover the activities of other governmental or non governmental agencies, except where they directly interlink with the task of identifying organisational infrastructures in relation to health education. Its main purpose is to chart WHO's past activities in health education in an attempt to understand their present and future role in the wider health promotion strategy.

Early Beginnings at Global Level

From its inception, the Constitution of the World Health Organisation stated that "informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people" (WHO, 1981). In 1953 a WHO Expert Committee on Health Education of the Public reaffirmed this principle and specified the need to give attention to "implementing carefully planned field studies, research and experimental programmes in this field" (WHO, 1954). This was followed in 1958 by a further Expert Committee on Training of Health Personnel in Health Education of the Public (WHO, 1958). It recommended studies to be carried out on a global scale to determine the nature of preparatory training offered to doctors, nurses and health education specialists. It went further to propose that WHO compile, publish and disseminate technical information on research in training and in research methods in health education. The 1959 World Health Assembly Technical Discussions were held on the theme of health education. A WHO Expert Committee in 1967 specified research as a function of a national health education service (WHO, 1969a). Further emphasis was given to research in health education in the report of a WHO Scientific Group in 1969 (WHO, 1969b). It is relevant to note that this Group used the following limited definition of health education:

". . . usually means the planned or formal efforts to stimulate and provide experiences at times, in ways, and through situations leading to the development of the health knowledge, attitudes and behaviour that are most conducive to the attainment of individual, group or community health".

Dr Leo Kaprio reported at this time (German Federal Centre for Health Education, 1972) that the "Regional Office for Europe has had a very limited programme—supporting a few seminars and some post-graduate training—but only limited funds have been available". He went on to announce that the Regional Office would appoint a full time professional staff member with responsibility for "developing the administrative and scientific approach to health education within the Region" (subsequently appointed in 1973). He also promised an expanded programme to promote the development of health education.

The Place of Health Education in Health Administration

At the World Health Assembly held in May 1974 the Director-General of WHO was requested to bring to the attention of member states the need for the inclusion of health education activities in all health and other related programmes. The WHO Regional Office for Europe's expanded programme in health education began in 1974. As part of this programme it convened a meeting in 1976 to examine the place of health education in the health administration of various countries (WHO, 1977). They found that various structures could be drawn of the models of health education operating in the Region—through departments at central health administrative level, through councils and through voluntary organisations subsidised by the central health administration, for example. All these structures showed varying degrees of integration of health education in health administration systems. They reviewed in detail the infrastructure prevailing at that time and highlighted four simplified structures—Unit in a Health Ministry, Council outside the Health Ministry, autonomous agency with a co-ordinating committee and autonomous agencies. They examined the advantages and disadvantages of such structures. The working papers prepared for the meeting highlighted the following points—the need to consider the role of field health educators, the need for legislation to support health education, a comparative analysis of health education methods was needed and it should be related to the various health priorities of different countries, further professionalisation of health education activity was needed, need for further knowledge on the prevention and treatment of behaviour concerning health threats and an appropriate organisational framework for health education services needs to be built up. The Working Group agreed from the outset that it was not possible to produce a recommendation of one "best" model of health education

services, in the same way that there is no "best" way of organising the health care of a country. They stated that health education "must be organised to fit the value system, organisational structure and health problems of each country in the Region". They felt that although each country had different priorities and different approaches there were certain shared characteristics, i.e. sound theoretical base, professional responsibilities and well planned and evaluated programmes. Therefore, although there was no optimum model suitable for all European health care systems, and the organisation of health education services should be system-specific, there was a need for shared standards. The working group agreed on the following conclusions:

(*a*) Health education structures are to a large extent governed by existing socio-political systems and are the best initial positions from which to develop.
(*b*) Health education should be integrated in a planned way into the total health service, i.e. there was a strong need for national health programmes of which health education was a part.
(*c*) Co-ordination of activities in health education was necessary.
(*d*) Centralisation was advisable.
(*e*) It was important to educate and influence policy makers.
(*f*) Don't raise public expectations without fulfilling them.
(*g*) Evaluation was a necessary component of programmes.
(*h*) There was a need for qualified health education personnel.
(*i*) Health education training was important.
(*j*) There was a need for the development of career structures.
(*k*) Political will was necessary for the allocation of resources.

As a result of its deliberations the Working Group made the following recommendations:

(i) health education should be integrated in the total health service and be part of national health programmes;
(ii) co-ordination and pooling of resources was desirable for health education;
(iii) regardless of the central administrative organisation the concerted and educated support of policymakers and health administrators was essential;
(iv) health administrators should initiate health education where no services exist;
(v) the health education component should be planned by health educators;
(vi) WHO to investigate role of mass media;
(vii) checks should be built in to maintain a high degree of professional responsibility;
(viii) evaluation, both long- and short-term, should be built in;

(ix) create systematisation of knowledge and creation of internationally comparable scientific methodologies in health education;
(x) the need to strengthen health manpower in health education (appropriate career structures, etc.).

Principles and Methods of Health Education

In 1976 the World Health Assembly approved the Sixth General Programme of Work for the World Health Organisation for the period 1978-1983. Under that programme health education and information of the public were to be promoted, with particular emphasis on the responsibility of the individual and active community involvement. Therefore as a natural continuation of the Symposium on the Preparation of Health Personnel in Health Education (WHO, 1974) and the above Manchester Working Group, a further Working Group was convened in Dresden in 1977 (WHO, 1979). The purpose of this meeting was to try to identify common denominators and thereby strengthen the professionalisation of health education practices in the European Region. It was felt that the process of health education should be responsive to change. The Working Group were asked whether health education should operate within the existing health services (as part of preventive medicine) or should resist being "medicalised". The aims of health education were put forward as—to promote self-reliance, to increase participation in community affairs and to increase responsibility for individual and family health (based on an assumption that people were free to choose). The Working Group produced the following "principles" of health education:

(*a*) the community as a whole must take responsibility for health education;
(*b*) health education should be organised in an efficient and planned fashion;
(*c*) health education should be founded on a scientific basis, its methods should be scientifically tested and evaluated, and in order to achieve this research into health-related behaviour is required;
(*d*) health education should activate the population to protect its health and enhance personal responsibility for health;
(*e*) there is a special role for medicine and the health service in health education;
(*f*) health education should be differentiated and oriented according to target groups.

It was recommended that governments consider the above "principles" when planning, organising and directing health education; a study of training needs in health education be undertaken; collaboration with non-governmental organisations in the field of health education should be

undertaken and there was a need for the systematic development of health education methodology. Therefore as part of the 6th Programme of Work, WHO undertook to encourage countries to define and/or improve their health education policies.

What can be expected from Health Education Programmes?

At its first meeting the European Public Health Committee of the Council of Europe took the subject "What can be expected from health education programmes? as the theme for its 1978 Co-ordinated Medical Research Programme. They established a study group which reported in 1980 (Council of Europe, 1980). This study group found that plans for health education in Europe were rare: "planned efforts of health education are not yet sufficiently included in national health plans. . . . Weaknesses in overall policy development and planning. . . . form constraints to wider concepts and programmes for health education". They concluded that health education should be included in the development of national health policy and national plans for health; it should be supported through manpower and financial resources as part of general resource allocations for health development; administrative and where necessary legislature measures should be taken to ensure co-operation/ co-ordination between different government departments and between government and voluntary organisations. They repeated the advice of the WHO Working Group (WHO, 1977): "centralisation insofar as it relates to organisation, finance and staffing is advisable when it is comparable with the socio-political structures of a country and takes into account the valuable contribution that voluntary and statutory organisations, including the mass media, have to offer". The Study Group reported that there was a need for a focus within ministries of health with special designated responsibilities for the promotion of health education. Interestingly enough, they also mentioned for the first time, the need for a similar focus within ministries of education. "Centrally organised health education units should be supported by health education organisers working at the periphery, they should enlist health professionals and support them with expertise and materials". The need for appropriate training and research were also highlighted.

Alma Ata and a New Health Education Programme for Europe

Education was recognised as fundamental to the attainment of Health For All by the year 2000. The International Conference on Primary Health Care (Alma Ata) identified education as the first of eight essential components of primary health care (WHO, 1978). The achieving of "Health For All" called for new and imaginative approaches in health

education. These new approaches included seven basic orientations as follows; health education should:

(i) work with new images and a positive concept of health;
(ii) make use of innovative educational approaches;
(iii) choose a multi-sectoral, multi-disciplinary approach;
(iv) be geared towards lay participation and community action;
(v) develop new strategies on all levels of action (governmental, professional, community).

The European Office of WHO therefore developed a new programme in health education with three main objectives:

(*a*) to clarify the role and strengthen the impact of health education in health promotion;
(*b*) to develop preventive health education programmes from the standpoint of strategy, technology and ethics;
(*c*) to develop models of health education to support patients and their families in coping with disease and disability.

The Regional Programme in Health Education and Lifestyles (Berlin, 15-19 September 1981) (WHO, 1981) pointed out the high relevance of health education for the promotion of lifestyles conducive to health: "Health educational concepts have, of course, taken different directions in Member States; these are related to the historical and political development of the health services, the extent and form of institutionalisation of health education itself, cultural attitudes and beliefs and the main health priorities set in the national context."

Reference was also made at this time to a "new supplementary role" for organised health education that works through "natural social institutions and networks"—family, school, peer group, neighbourhood and community. A new Regional Officer for Health Education was appointed in 1981. Kickbusch (1981) reported that "finding effective strategies for health education in the present European situation is . . . a formidable challenge".

Council of Europe

Developing from its meeting of European Ministers responsible for public health in 1978, the Council of Europe began a series of reviews of prevention and health education during the period 1978-81. Their first report was a review of Prevention Strategies in their member countries (Council of Europe, 1981a). Their second report was directly related to health education and made a series of recommendations on organisation and structure (Council of Europe, 1981b). This report referred to education for health and recommended that it should be part of health policy and that it should be more structured and systematic. They saw the

setting-up of a central co-ordinating structure or central body as a feature for the promotion of a co-ordinated health education policy. They acknowledged that health was influenced by factors outside the health sector, and that methods of bringing out interministerial co-operation and intersectoral planning would have to be developed, with legislative support as necessary. To ensure adequate co-ordination of activities they recommended that central and local authorities should seek the co-operation of voluntary organisations. Finally, the report, referring to action at community level, stated that health education should be based on primary health care services.

Early Development of the WHO Health Promotion Programme

A major overview of health promotion was commissioned by WHO Euro at this time, and eventually appeared in the European Monograph Series (EMHER, 1984). It consisted of a literature review since 1975 and a report on a Study Tour made to North America during 1982. A Working Group met in 1981 at the European Office to discuss for the first time the concepts and principles of health promotion. Little mention was made of the role of health education, except to say that "existing health education offices may act *in the first place* as resource centres" (WHO, 1982). The three main thrusts of the Sixth General Programme of Work of the European Region (health promotion, education for prevention and supportive health education) were widened to include lifestyle aspects. The importance of the social environment and the role of individual responsibility in contributing to community participation in health was stressed (Kickbusch, 1981). A paper, presented on behalf of the WHO Programme, at the Hobart World Health Education Conference in 1982 differentiated between individual and community lifestyles (see EMHER 1983). A series of meetings followed to further develop the lifestyles and health concept—lifestyles and living conditions and their impact on health in 1982 (EMHER, 1983) and later in that year the role of legislative measures in the development of lifestyles conducive to health (Institute for Health Education, Dresden 1983). The latter meeting acknowledged the role of legislative measures as an important pre-condition for an increase in the effectiveness of health education. The outcomes of these meetings and others, let up to the Technical Discussions at the 33rd Regional Committee in Madrid on the effects of living conditions and lifestyles on health (WHO, 1983).

New Policies for Health Education in Primary Health Care

The Technical Discussions at the Thirty-Sixth World Health Assembly also included the role of health education (WHO, 1986a). One of the

recommendations made was that health education should receive a strong mandate from national policies which "assure that there is a central unit within the framework of health services, staffed by specialists in health education with resources required to carry out its function, and placed on the same administrative level as other essential health services to permit access to all other units concerned with health education". They referred to the need for health education units at local, state and central levels of the health organisation; that these units should be staffed by a multi-disciplinary team, comprising of workers specialising in health education, mass communication, audio-visual techniques and behavioural sciences. They highlighted the following core functions: to muster political will; to plan, implement and evaluate health education; to co-ordinate and collaborate; to carry out research and training and to stimulate community action. In their recommendations to WHO, they emphasised the need for WHO to co-operate with member states in strengthening the health education services so that they would be able to assist all other services in their health education functions. They further observed that "the setting up or strengthening of an institutional framework at the national level, responsible for co-ordinating the planning, implementation and evaluation of national health education programmes, *is essential*". It is also relevant that they referred to health education as "an inter-disciplinary and inter-sectoral process that has as its final goal the promotion of health in its broadest context".

Concepts and Principles of Health Promotion—In Action?

The Regional Director of WHO reported in 1983 that the health education unit had developed "a conceptual framework in health education, including the role lifestyles play in health promotion" (WHO, 1984a). The practical implications of such a framework for health education was not established. In the seminal discussion document from the Concepts and Principles of Health Promotion Working Group (WHO, 1984b) health education was not referred to specifically but the following indirect references made—improvements in health require information and lifeskills; health promotion *combines* diverse but complementary methods and approaches, including communication, education and community development; information and education provide the informed base for making choices; they are necessary and core components of health promotion which aims at *increasing knowledge and disseminating information* related to health; important role of the mass media and new information technologies. The role of health education per se was not included in the priorities for the development of policies in health promotion. The document goes on to state that information alone is inadequate; raising awareness without

increasing control or prospects for change may only succeed in generating anxieties and feelings of powerlessness.

From this conceptual stage we can examine whether the role of health education has been clarified subsequently in practical terms. In the WHO meeting on the practical aspects of implementing health promotion programmes (WHO, 1985a) once again health education is not referred to in specific terms. References are made as follows—there are "a number of approaches to promoting good health at the level of the individual and of the community. The relative combination of each should be carefully considered"; these approaches included:

Personal education and development—improving knowledge about determinants of health, teaching new skills, promoting self-esteem, self-empowerment skills.

Personal services—preventive medicine services, lifestyle support services.

Mass media information and education—to create climate of opinion, raise awareness.

Community-based activity—formation of self-help and pressure groups, networks for social support.

Organisation development—change through schools, hospital catering, counselling services.

WHO acknowledged in 1985 that health education is currently undergoing a major reworking and transformation across Europe (WHO, 1985b). WHO EURO has recently made a move towards broadening the focus to public education and information for health—health education in the wider context of healthy lifestyles and health promotion (WHO 1986c). In the WHO discussion document: "A Framework for Health Promotion Policy" little mention is made of health education (WHO, 1986b) but it does refer to the need for an organisational focus for health promotion policy, "a visible organised entity charged with overall responsibility for carrying out the new enabling and advocacy roles of the health sector. This focal, policy activating unit must have the capacity to lead the implementation of all designed policy strategies directly or through other organised bodies". It further states that such a unit must have the capacity to carry out its "analytic and educational, co-ordinating and collaborative, mobilising and advocacy roles" including personal health information, collaborative training and educational programmes, knowledge and skills for community action for health and the development of persuasive information to improve the political feasibility of healthy public policy. Under this framework and included in health promotion policy are "provision of direct health information/education

services, developing and supplying information in diverse forms for individuals, the general public, organisations and the press". But lifestyles are seen in this context as collective phenomena (i.e. socially and culturally constructed) and are the properties of whole groups and whole societies and not just a characteristic of individuals. Therefore, in order to change individual behaviour, one has to change "the underlying and predisposing conditions of life and modify powerful social and economic forces" that encourage health damaging lifestyles (WHO, 1986d).

Education was acknowledged as a basic prerequisite for health in the Ottawa Charter (1986e) which included access to information, life skills and opportunities for making health choices in health promotive action. In this Charter, under the definitions of Health Promotive Action, are included:

Building Healthy Public Policy—which takes the definition of health promotion from the 1984 Concepts discussion document but *excludes* communication, education, community development and spontaneous local activities against health hazards.

Strengthening Community Action—"community development requires full and continuous access to information, learning opportunities for health, as well as funding support".

Developing Personal Skills—"health promotion supports personal and social development through providing information, education for health and enhancing life skills".

Health Education and Health Promotion

Although it is not primarily the purpose of this paper to examine conceptually the developing debate between health education and health promotion, it is worth briefly reflecting on its historical relevance. The role and function of health education began to be questioned towards the end of the 1970s. It had traditionally been concerned with matters of personal hygiene, sanitary education, information about health services and use of resources. Draper et al (1980) introduced for the first time a typology of health education which referred to the above traditional functions as Type I and Type II. They extended the remit of health education by proposing a Type III which would aim at producing education and information for the general public on the positive and adverse effects of local, regional or national policies which are enacted without full regard for their consequences on people's health. The health promotion/health education debate was primarily developed from two schools of thought, either side of the Atlantic. In the United States, which had always been more advanced in health education, health promotion was seen as "any combination of health education and related organisational, economic and environmental supports for behaviour

conducive to health in individuals, groups or communities" (Green, 1986). This definition emphasises the intervening character of health education and puts health education at the centre of health promotive actions. The European (WHO) concept and definition of health promotion saw it as a process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health (WHO, 1986b). If we can concentrate on the role of health education in this debate, Baric (1985) highlighted the danger that the development of health promotion could destroy health education as it existed in its traditional sense. In the United Kingdom, where there is a separate and well-developed health education service, the confusion between health education/health promotion is destructive insofar as it inhibits the development of health education and prevents full development of health promotion. Again in the UK, Ewles and Simnett (1985) see health education as the basis for health promotion; they offer a useful definition which adds to the confusion: ". . . health education is a tool which enables people to take more control over their own health, and over the factors which affect their health. This includes the physical and social environment (workplace, living conditions) as well as their personal habits and lifestyle. Health education is not only the process by which knowledge is obtained, but it is also the process by which values and attitudes are explored, decisions are made and action is taken. Health education can help people to become self-empowered, and thus to help themselves and others towards a healthier life". Other recent examples add to the confusion. Fisher et al (1986) from an Australian context acknowledged that the concept of health education has broadened in recent years to include a range of educational activities designed, not only to improve the health behaviour of individuals, but to improve living conditions via legislative and environmental changes. They refer to health education as part of any health promotion endeavour aimed at improving the quality of life, and can be seen as an essential precursor to those improvements. Recently de Leeuw (in press) has proposed a Type IV health education, i.e. education and information aimed at politicians, policy makers, pressure groups, etc, about the factors that shape the prerequisites and conditions for health in its widest sense. Similar views were expressed in a UK context, where health education was seen to be about enabling and empowering not just for individuals but as a quality of the community and society (Lambert et al, 1986). The workshop participants went on to recommend that health education should not just be aimed at "the public" but should be directed even more powerfully at policy makers—both administrators and politicians, funders and professionals. Saan (1986) has attempted to differentiate between health education and health promotion in order to allow both to develop. He sees health promotion as improving health by increasing control over the determinants of health by means of intersectoral action and healthy

public policy. Health education, on the other hand, he sees as focusing on the individual but always referring to group forces and societal conditions as the context; offering opportunities for learning and building a system of continuous education for health. In order to develop health education further, "as a separate but not isolated sector", he goes on to say that we must ensure that health educators are able to engage in intersectoral activity with "a clear sense of identity, a clear contribution and ability to adapt to wider health promotion strategy".

Recent Developments—Education for Health or Health Education?

Early this year the European Advisory Committee on Health Research reviewed the health education programme in the Regional Office. They acknowledged that in the light of the 1984 Concepts and Principles document and the Ottawa Charter a clear and concise conceptual framework for health education needs to be established. They reported that health education has a considerable body of knowledge already accumulated on the relationship between health behaviour and lifestyles and health outcomes. But they warned that with the increased emphasis on health promotion, which focuses on whole populations and deals with the causes of health by a variety of complementary methods, some questions are raised as to the role of "health education" in its more traditional sense (WHO, 1987a; Shuval and Stacey, 1987). They stated that health promotion creates the environment in which health education functions; health education has a "*supportive*" role; under the umbrella of Health Promotion, Health Education "has become more clearly identified *as an approach and method in the promotion of healthy lifestyles*". The Committee reported that the medium term programme of WHO has a major role to play in developing organisational infrastructure and they emphasised the importance of Country Programmes for developing an organisational infrastructure for health education and health promotion. Therefore WHO's own recent planning documents have also emphasised the need for a co-ordinated and integrated approach to analysing the needs and developing both health promotion and health education: "New perspectives in health education and health promotion are being developed, with more emphasis being placed on intersectoral collaboration and the building up of sound infrastructures". "A co-ordinated and integrated approach is needed to analyse needs and to develop education for health in all Member States." "The development of an information base on a co-ordinated organisational infrastructure for education for health in Member States" is needed . . . and strengthening the role of WHO/EURO as a "health education intelligence unit" . . . including the means of collecting and disseminating "innovative educational approaches" (WHO, 1987b).

Whatever recent difficulties in agreeing on the definition of the role of

health education in health promotion (IUHE, 1987; O'Byrne, 1987) health education is and will remain an important core aspect of health promotion. "Health promotion depends in essence on the active involvement of an informed public in the process of change. Health education represents a crucial tool for this process" (WHO, 1985c). Target 15 of the WHO European Strategy aims to give opportunities and strengthen people's capacities for healthy lifestyles through *programmes for health education*. The relationship between these programmes, the WHO Euro's recently re-termed "education for health" programme and the programmes of individual member states needs to be examined in depth.

"All over Europe there is today a rapidly growing interest and emphasis on communication for health, health education, health promotion, health advocacy and health literacy. My own definition is 'responsible sharing of information about health and disease'" (Hellberg, 1987).

References

Baric, L. (1985). The Meaning of Words· Health Promotion. *Journal of the Institute of Health Education*, Vol. 23, No. 1, pp. 10-15.

Council of Europe (1980). *What Can Be Expected from Health Education Programmes?* 1978. Co-ordinated Medical Research Programme, European Public Health Committee, Strasbourg.

Council of Europe (1981a). A European Approach to Health Promotion: *Prevention*. First Report, Conference of European Ministers responsible for Public Health. Strasbourg.

Council of Europe (1981b). A European Approach to Health Promotion: *Education for Health*. Second Report, Conference of European Ministers responsible for Public Health. Strasbourg.

Draper, P., Griffiths, J., Dennis, J., Popay, J. (1980). Three Types of Health Education. *British Medical Journal*, 16/8/80, pp. 493-495.

De Leeuw, E. (in press). *Policy Planning for Health Promotion: A New Role for the Media*. Proceedings of the First European Conference on Health Education, Madrid, 1987.

E.M.H.E.R. (1983). *European Monographs in Health Education Research*, No. 5. Scottish Health Education Group, Edinburgh (p. X).

E.M.H.E.R. (1984). *European Monographs in Health Education Research*, No. 6. Scottish Health Education Group, Edinburgh (pp. 1-126).

Ewles, L. and Simnett, I. (1985). *Promoting Health. A Practical Guid to Health Education*, Wiley. New York.

Fisher, K. F., Howat, P. A., Binns, C. W., Liveris, M (1986) Health Education and Health Promotion—an Australian Perspective. *Health Education Journal*, Vol. 45, No 2, pp. 95-98. London

Green, L. W. et al (1986). *Measurement and Evaluation in Health Education and Health Promotion*. Mayfield Pub. Co., Palo Alto.

Hellberg, H. (1987) Health for All and Primary Care in Europe. *Public Health*, 101, pp. 151-157.

Institute for Health Education (1983). *Healthy Lifestyles. Motivation and Legislative Measures*. Dresden.

I.U.H.E. (in press). *The Role of Health Education in Health Promotion* International Union for Health Education, Paris.

Kaprio, L. (1972). Perspectives of Health Education in Europe. In *Health Education in Europe*. German Federal Centre for Health Education, pp. 1-3. Cologne

Kickbusch, I. (1981). Involvement in Health: A Social Concept of Health Education. *International Journal of Health Education*, Vol. XXIV, No. 4 (Suppl.). Geneva.

Lambert, D., Spratley, J., Bewley, B. (1986). *Personal and Professional Development for Health Promotion: An Evolving Programme*. Report of a Workshop, Harrogate, 1985. Health Education Council/London School of Hygiene and Tropical Medicine.

O'Byrne, D. (1987). *Health Education and Health Promotion*. First European Conference on Health Education. Madrid.

Saan, H. (1986). Health Promotion and Health Education: Living with a Dominant Concept. *Health Promotion*, Vol. 1, No. 3, pp. 253-255. Oxford.

Shuval, J. and Stacey, M. (1987). *Review of Euro Programme on Health Education*. E.A.C.H.R. 13th Session, Copenhagen.

WHO (1954). *Report of the Expert Committee on Health Education of the Public*. WHO Technical Report Series, No. 89, p. 33. Geneva.

WHO (1958). *Report of the Expert Committee on Training of Health Personnel in Health Education of the Public*. WHO Technical Report Series, No. 156. pp. 35-36. Geneva.

WHO (1969a). *Report of the Expert Committee on Planning and Evaluation of Health Education Services*. WHO Technical Report Series, No. 409. Geneva.

WHO (1969b). *Research in Health Education*. A Report of a WHO Scientific Group. WHO Technical Report Series, No. 432. Geneva.

WHO (1974). *Report of the Symposium on the Preparation of Health Personnel in Health Education, with Special Reference to Postgraduate Education Programmes*. Cologne, Copenhagen.

WHO (1977). *The Place of Health Education in Health Administration*. A Report of a WHO Working Group, Manchester, 1976. Copenhagen.

WHO (1978). *Primary Health Care. Report of the International Conference on Primary Health Care (Alma Ata) 1978*. "Health for All" Series, No. 1. Geneva

WHO (1979). *Principles and Methods of Health Education*. A Report on a WHO Working Group. Euro Reports and Studies 11, Dresden 1977, Copenhagen.

WHO (1981). *Regional Programme in Health Education and Lifestyles*. (EUR/RC31/10). Copenhagen.

WHO (1982). *Working Group on the Concepts and Principles of Health Promotion*. Copenhagen 26-28 November 1981 Summary Report.

WHO (1983). *Lifestyles and their Impact on Health*. Madrid. (EUR/RC33/Tech Disc/1). Copenhagen.

WHO (1984a). *The Work of WHO in the European Region*. Annual Report of the Regional Director for 1983, p. 31. Copenhagen.

WHO (1984b). *Health Promotion A Discussion Document on the Concept and Principles*. Copenhagen.

WHO (1985a). *Report of the WHO Working Group on Practical Aspects of Implementing Health Promotion Programmes*, Cardiff Copenhagen.

WHO (1985b). *Regional Programme Committee*. Copenhagen (unpublished).

WHO (1985c). *Health Promotion Glossary*. Copenhagen

WHO (1986a). *New Policies for Health Education in Primary Health Care—a Review based on the Technical Discussions held during the 36th World Health Assembly 1983* Editor: L. W. Green. Geneva.

WHO (1986b). *Health Promotion Concepts and Principles/In Action/A Policy Framework*. Copenhagen.

WHO (1986c). *The Work of the WHO in the European Region*. Annual Report of the Regional Director 1985, Copenhagen

WHO (1986d). *Vienna Dialogue on "Health Policy and Health Promotion—towards a New Conception of Public Health"* Report on a WHO meeting, Copenhagen.

WHO (1986e). *Ottawa Charter for Health Promotion*, WHO, Health and Welfare Canada, Canadian Public Health Association

WHO (1987a). *Review of the WHO Health Education Programme* E.A.C.H.R. (unpublished).

WHO (1987b). *Target 15*. WHO International Planning Document 2/4/87. Copenhagen (unpublished)

Annex 3

A Proposed Model of Good Practice for Health Education

Paper presented at the WHO Consultation on Co-ordinated Infrastructure for Health Education, Copenhagen, 11-12 June 1987

by H. Hagendoorn

1. Introduction

In this article, I will offer you a model of good practice for health education. But you are a group of distinguished experts who have already undoubtedly all thought over the problem of models many times! And what is good practice? Let me be modest. I offer you a mixture of private experiences as a health educator in the first part of my career, as policy-maker in mental health education in the second part, and as director of the Dutch Health Education Centre in the third. As a member of the executive committee of the International Union for Health Education (IUHE), I have thought over some questions of the Union's policy, mainly in Europe, but these are private ideas.

A bit more official, or based more on formal practice anyway, are the developments concerning health education and promotion in the Netherlands. Last but not least, there is the development of the concept of health promotion in WHO, to which collaborators of the Dutch Centre (I mention here especially Hans Saan) have had an important contribution.

So those were my credentials, in addition to the fact that I am a political scientist, specialising in mass psychology and mass communication.

I will structure my contribution as follows:

personal experience;
my view on the relation between health promotion/health education;
the Dutch health education model;
the Union: a model for Europe;
WHO: its major contributions;
the European Community (EEC);
conclusions.

2. Personal experience

When I began my first health education job, I had to train mainly women who went into schools and all kinds of other organisations, such

as churches, women's organisations and social workers, to give information on and educate about sexual and relationship issues. Although the Netherlands is a small country, it was an impossible job. I trained the trainees, but what I needed was a stable organisation all over the country that would be a well organised base for sexual education; that would gather information, make materials and develop methods; that would train people to disseminate the message; that would consider the advantages and disadvantages of various approaches; and that would base its activities on solid evaluation and research. I did the job for six years, and to a certain extent all went well, but not as well as it could have been. It lacked a solid infrastructure, which in later years proved to be a great disadvantage to the work.

My second job consisted of creating conditions for the development of primary prevention in outpatient mental health institutes, which had only recently been established in our country. I—but not I alone—succeeded in creating an infrastructure in which there were in every centre paid mental health educators, mostly at an academic level, who, preferably in co-operation with therapists, carried out prevention programmes.

A network of health education workers was therefore created all over the country, solidly financed, and supported by a national organisation. Much of the infrastructure was still lacking to a certain extent, e.g. gathering epidemiological data, standardising programmes and carrying out research, but when I left that job after six years a rather solid structure existed, with many programmes being carried out. That was certainly more than in my first job. However, the mental health education workers had complaints. They were able to carry out all kinds of programme, but the main causes of many mental health disorders lay outside their scope of work: in modern society, with its noise, unemployment, stress, luxury, lack of ideals, etc. In other words, many preventive actions could not be done by them but had to be carried out by others outside the health system.

In my present job in the Dutch Health Education Centre, I fully realise the importance of having a well functioning structure that guarantees the quality development of health education in the Netherlands. Policy is made at national and regional levels, so there is official support from the government and private organisations. There is a guaranteed flow of money and a system of improving the quality of work. Besides the structure, there is an underlying philosophy that places health education development in a context that creates a supportive climate. At this point in my professional career, I have reached two conclusions that are important for a model of good practice: health education can only be successful in a context broader than health care alone, and health education needs a solid structure—otherwise it is transitory and unreliable.

3. Relation between health education/health promotion

Some years ago, I became familiar with the concept of health promotion. It was for me what the Germans call an "Aha Erlebnis", something new, which sets things in their place. Perhaps because it offered me the missing link in the chain of health education: health education can only stay alive in a political environment that thinks in terms of the promotion of health, through not only individual and group behaviour but also legislation and structural measures, extending the boundaries of traditional health care. The concept goes even further. It is a new approach to public health: thinking from the side of expanding health and not from the point of setting limits to illness.

Health promotion cannot be thought of without the intersectoral approach, without community action, without supportive environments or without the reorientation of health services. The Ottawa Charter for Health Promotion clearly states all these elements in addition to the important objective of developing personal skills.

In school, we used to learn the Ten Commandments by heart, to secure a better everlasting life. Perhaps it would be useful to formulate a credo out of the Ottawa Charter in matters concerning health for every student. However, as you know, it has been proven that it is very difficult to put the Ten Commandments into constant practice, and I predict that it will be very hard to practise the health beliefs of Ottawa in our daily lives to secure a better world before our deaths. It is not meant as a critique but as a simple fact. Health promotion is a challenging, comprehensive political idea, which can only be brought into practice by separate, preferably co-ordinated, actions. One of these actions is health education.

It is my opinion that health education and health promotion are not interchangeable concepts. To replace health education by health promotion seems to me to be a nearly irreparable mistake. They are concepts of a different order, comparable with the words *car* and *traffic*. *Car* is special and *traffic* is general. On the other hand, the thought that health promotion can do without health education is also an error. Education is an important element of promotion. Traffic without cars is hardly thinkable, too!

I will now put it a little simpler and, hopefully, clearer. I consider the controversy between the WHO concepts of health promotion and health education, advocated by the IUHE in Ottawa, to be unfruitful and detrimental to the common cause. Perhaps the concept of health promotion has different connotations and that is the reason for much confusion. According to my opinion, it is a container concept of health-related measures comprising:

behaviour: information, education, emancipation, etc.;
measures: traffic safety, food ingredients, noise reduction environmental improvement, health care access, etc.;
legislation: economic, financial, social, etc.

My conclusion to this part of my contribution is that the idea of health promotion sets health education in the right context. That is the harvest of the WHO activities in this field over the past years, which is a tremendous gain!

4. The Dutch health education model

4.1 *General comments*

In talking about the Dutch situation, I fully realise that it is very different from that of other countries. Each country will have to find its own solution, and I am aware that the Dutch solutions are not usually transferrable to other countries without some changes. Just remember, therefore, that I speak of the situation in the Netherlands as an "is" and not as an "ought". Besides, building models is mostly a long process, with ups and downs. We have not yet reached our destiny; we are only on the road and still have a long way to go. However, I am not as humble as I perhaps seem to be, for there can be international profit from our experience in the Netherlands.

Let me remind you of the two elements that I consider essential, nationally as well as internationally, to the development of health education: the right context and the right structure.

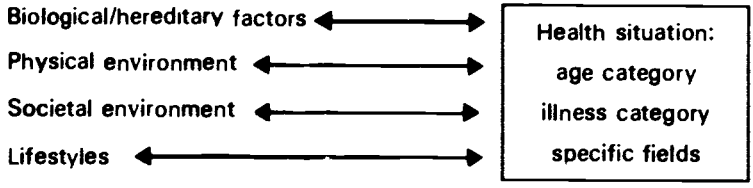
4.1.1. *The right context*

As I just told you, I consider the context of health promotion essential to the development of health education. In the policy papers of the Dutch Government, the idea of health promotion appears in a white paper of 1985: Health Care Policy by Limited Means (especially limited financial means). Before 1984, health care policy had mainly been directed towards structuring the organisation of health care and financing the health care system. In 1984, the element of health promotion was added, and it incorporated the idea of health education and primary prevention. There was no financial translation of this change in policy, but nevertheless the right context was created.

I will not go into further detail over how this remarkable milestone was reached and what it actually meant for health education, but it was more or less the creation of a new perspective, which did not cause much turmoil in the world of health care because there was no financial label on it. Nobody cared really or so it seemed.

A second milestone was reached in February 1986. An extensive White Paper on health policy until the year 2000 was published. Although not formally accepted in Parliament, it triggered many discussions. The White Paper consequently placed health policy in the context of health promotion and not in the setting of health care. The model used in the White Paper was essentially based on the Lalonde report from Canada

in 1974, one of the initial creators, in my opinion, of the health promotion idea. The following is the main model on which the paper was written:



In its analysis of the health situation of the Dutch population in the following fifteen years, much attention was paid to health education and the many factors outside the health system that nevertheless affect the system fundamentally.

This year, another important report was published that will influence the development of our health system considerably, mainly by pleading to commercialise the system. What this will mean to health promotion and health education cannot yet be said, but at this moment I do not think it will affect the health promotion philosophy directly, although I think health promotion will flourish more in a controlled state system than in a market-directed economy.

There is now one important question that should be asked before I stop talking about the right context: health promotion. That question is how is it possible that health education expanded so much in the Netherlands before the concept of health promotion became an accepted idea? I have to admit that health promotion is not necessary, but it is a facilitator, at least in the beginning of development.

In the long run, it is needed as a leading context. Otherwise, health education will always stay in the shadows of illness prevention and in the confinement of being the hardly tolerated preventive predecessor of the always dominant care. Health education can therefore develop to a certain extent, but to become fully grown it should change to another context.

4.1.2. *The right structure*

I started this contribution by telling about my experiences, and I said that a structure for development is needed. It is a prerequisite that should not be overlooked. Incidental actions are not sufficient. No science can develop without the systematic development of a body of knowledge, and no activity can be carried out if the right institutions do not exist.

Health education in the Netherlands is carried out in the health care system by the workers (doctors, nurses, dentists, dietitians, therapists, etc.), but their activities stay incidental if they are not supported by

specialists in health education. Therefore, in the different sectors of health care, hundreds of activities and projects are carried out systematically, mainly by academically trained health education professionals. There are several hundred of them, being paid by regular funds. Health education has become an integral part of the system.

Many activities are carried out, mainly on a national scale, by national institutes on topics such as cancer, smoking, eating and drinking, and national campaigns are mainly undertaken by these institutes.

At government level, the Department for Health Education is located in the Ministry of Health, which has an important function in watching for new legislation, taking incentives to new policy and stimulating developments. The Department has formal connection with other departments in the Ministry, and it has a vital function in the process of development of health education.

Health educators and the Government are supported by the Dutch Health Education Centre. The Centre has the goal of improving the quality of health education and stimulating new developments by documentation, training, research, development of appropriate methods, and registration of health education activities. It publishes a monthly journal.

Some universities offer postgraduate training, and one university (Maastricht) has special training in health education.

All people who work in the health education field are members of the Dutch Asssociation for Health Education, which publishes a scientific journal.

The most important sectors in health education are represented in the Commission for Health Education of the National Board of Health (an advisory board of the Ministry of Health).

Activities

In health care: primary health care, public health (preventive), mental health, hospitals (patient education), co-ordinating bureaux of health education.
In national institutes.

Policy

Department for Health Education, Ministry of Health.
Commission for Health Education, National Board of Health.

Support

Dutch Health Education Centre.
Universities.
Dutch Association for Health Education.

4.2. *Important elements for a good model*

What are the essential elements to guarantee qualified health education, which we obtained from the Dutch development?

Continuity in governmental and institutional policy.
Stable financing.
Trained experts to support the work.
Documentation, and compilation of knowledge.
Training and education.
Methods development.
Research.
Overview of activities.

Much can be said on each one of these elements, but I will not do that at this moment. I will only say this: we try in our country to pay attention, through the joint effort of many people and many institutes, to more or less all these factors. In this way, we create a solid structure for health education, something I needed so desperately in my first jobs. Of course, we are not yet where we want to be. We are only mid-way, but at least we have systematic results and that gives hope for the future.

5. The Union: a model for Europe

Health education does not stop at our borders. Europe is small and many of the area's problems are shared. Just think of the millions of people going on holiday each year: smoking, drinking, drug-abusing and having casual sexual intercourse in the present AIDS period.

First, let me pay some attention to the role of IUHE in Europe, then to the WHO Regional Office for Europe and, last, to the role of the EEC.

The Union is an organisation of member persons and organisations, carrying out actual health education work. WHO is an organisation of member states (governments). The EEC is an organisation of collaborating states in a process of unison.

I am convinced of the necessity to co-ordinate our successive efforts as much as possible. That's why I want to stress the importance of international organisations such as the Union, WHO and EEC/Council of Europe.

So Europe is becoming too small for only national health education activities. But there is more. It has been proven that health education is effective; especially data from the States point in that direction. If separated, I think we are in an unfavourable position to advance, which changes when we work together. We should therefore set up a joint policy of division of labour that will be profitable to us all in the long run.

IUHE is an organisation of professionals, working either within member organisations or as separate individuals. As in every organisation of professionals, the main goal should be the enhancement of the

profession and the improvement of the quality of the work. Quality improvement is therefore the key word. It should be done by the following elements, mentioned earlier: gathering information on documents and activities, organising and carrying out training, developing effective methods, doing research and disseminating the results of that research. In tabulation:

Activities	*School health*	*Patient health*	*Occupational health*	*Media*	*Aids, etc*
Registration					
Documentation					
Training					
Research					
Development of methods					
Organisation					

Of course, it is not realistic to assume that the Union, and certainly not the European Region alone, can undertake action in all these fields. We have to choose and divide the responsibilities. Personally, I would prefer to develop sections of school health, patient health, occupational health, etc., within the Union, under the supervision of the Regional Office.

All these sections will have to make a modest plan of activities for the next, say, five years. I am proposing this form of organisation because the different topics are of interest for the people more than general subjects such as training and research. The sections can have periodic conferences, publications, etc., about the results of their activities. Each section should have a small steering group to plan its activities. The Regional Office should be supported in this model by a small committee. All planning should be realistic, since the Union is very poor. Funds should be raised by the steering groups. The Union could also formulate a set of ethics for health education or a professional code.

6. WHO

I introduce here the role of WHO. WHO has the power to influence and motivate governments, first by creating the political context. I think that context is the Alma-Ata Declaration setting the strategy for health for all by the year 2000 and, last but not least, the context of thinking in terms of health promotion. This movement should be warmly stimulated and promoted.

WHO has done excellent work as an international organisation. This work should be continued and supported strongly by all of us, for it creates the political context needed in all Member States to build up a solid system of health education supported by our governments. Health education will then become not only an incidental initiative but also an activity wanted by the political system. This creates the possibility of stable funding in many countries, which up until now has been questionable.

Another very strong initiative, which should be promoted strongly, is the creation of a network of collaborating centres. Official WHO centres get official government support, which can mean financial continuity and continuity in activities over a certain period. I think that an integrated system of collaborating centres will be of the utmost importance for the effective development of health education. The centres can contribute to governmental and institutional continuity, which I mentioned as a prerequisite for the development of health education. They can also contribute to a more stable flow of money.

Within the context of the system of collaborating centres, many activities, mentioned above by the Union, can be carried out. Here, I would like to accentuate the very fruitful connection that can be created in this way between the Union and WHO. If we succeed in creating a system of centres that carry out activities according to the given matrix, I think that this will be an ideal marriage. Perhaps WHO can create priority issues that find the support of the various governments.

7. European Economic Community

In this context, I will not say very much about the possibilities for the EEC. In uniting Europe, we are integrating not only agricultural or steel policy but also health policy. In this context, there are tremendous possibilities for health education. The EEC can give political legitimation to health education, it can set political scenarios and can give financial support. As I see it, through the EEC, all kinds of activities, campaigns, etc., can be carried out within the European context, e.g., actions against smoking, drinking and AIDS. It can also put various items on the political agenda.

There are enormous possibilities here, although I am not blind to the dangers. In these days, the EEC should not be forgotten. However, the accent is on WHO and the Union, so I will say no more about the EEC.

7. Conclusions

In short, my conclusions are:

health promotion offers us an excellent context to develop health education;

quality improvement according to certain prerequisites is needed at national level;

the Union can carry out in detail many quality improvement activities at European level;

an important part of this can be done within the context created by WHO collaborating centres.

To conclude, these plans are ambitious, although not unrealistic. I am quite aware that the situation in many European countries differs greatly. Developments are not the same everywhere nor is the same amount of money available. However, if you are convinced that health education must play an important role in the future, I am convinced that we have to create a European system to support that development. We do not need to have a European institute of health education for that yet!

Annex 4

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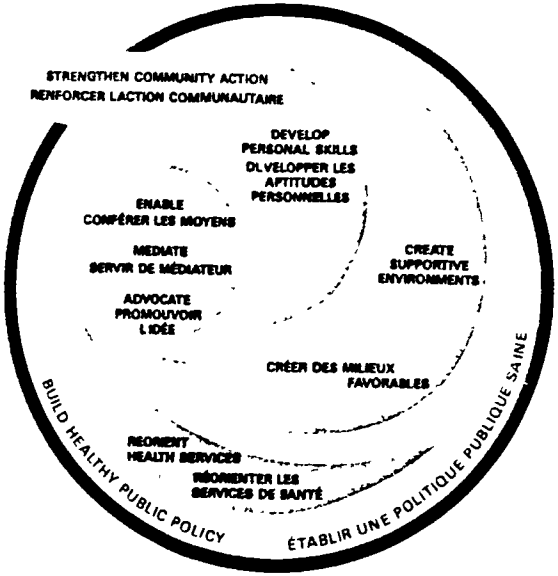

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