Community Health Education[1]

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We live in a time of change. But many Christians seem determined to avoid conflict by pretending the calendar still reads 1955. In matters of health and the development of effective community health programs, the old ways are tired and, more often than not, in need of updating.

A pre-test of our assumptions is a good place to begin. Look at the following eight statements and identify:

Those assumptions which you believe.

Those which you do not necessarily believe, but readily make (mostly because you haven't thought about it.)

Those which you know are not safe assumptions.

1. Health is largely a matter of people following sound medical advice.
2. Improvement of medical services is the first step toward community health.
3. If people want good health badly enough, they will get the resources somewhere.
4. People act on what they know.
5. Lack of information is the major reason for poor health.
6. Health education should begin with efforts to replace superstition with modern views of health.
7. People in hospitals and out-patient clinics are the most promising targets for health education.
8. People hear and evaluate health-related information as individuals; therefore, health education is a matter of considering *individuals*.

Now for the scoring of your responses:

- If you identified two or more statements as assumptions you believe, you are honest.
- If three or more are things you assume, but don't necessarily believe, you are humble.
- If you think all eight are *not* safe assumptions, you are correct.

Consider why each is a fallacy:

1. Health is largely a matter of people following sound medical advice.
   If this were true, we might as well give up before we wear ourselves out. There isn't enough of that kind of resource to go around. Furthermore, there are, after all, many places in the world where good health exists apart from sound medical advice.
2. Improvement of medical services is the first step toward community health.
   Improving medical services tends to focus on the remedial. Medical service is not the best first step toward community health; community health is better based on preventative measures. I am not opposed o remedial services—and certainly not to

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medical practice, but we must be careful not to assume that services calculated to remedy, repair, and bring things to normalcy are the first step toward, or even a primary element in community health.

3. If people want good health badly enough, they will get the resources somewhere.
   This happy thought is fine if you have a Western frame of mind, Western philosophy, and a Western notion of abundance of good things. Such access to needed resources is not feasible in much of the world, however.
4. People act on what they know.
   This claim is one of the most fraudulent arguments for education. Most educators know better. People act on the basis of habit and tradition far more than reason.
5. Lack of information is the major reason for poor health.
   Lack of information can be a reason, but rarely is it the major reason There are more complex factors involved when considering major reasons for poor health, particularly in terms of resources, habits, and motivations of people.
6. Health education should begin with efforts to replace superstition with modern views of health.
   This thinking encourages medical missionaries to move in and drop bombs rather than to build bridges.
7. People in hospitals and out-patient clinics are the most promising targets for health education.
   This common assumption is inadequate on two grounds: the audience is too limited and the focus in inclined to be on the narrow particulars that brought the person to the clinic or hospital (which, again, has more to do with remediation than prevention.)
8. People hear and evaluate health-related information as individuals; therefore, health education is a matter of considering *individuals*.
   Again, this assumption is probably a spill-over from Western thought. Northern Europeans, Americans, and Canadians are among the most individualistic people in the world. For most people of the world, however, life is more communal. Decisions that affect lifestyle are more a matter of community or family experience than of personal decision.

If we are serious about community health and community health education, we must look at the assumptions (above) and then get a viewpoint of the community itself. In a community context, *information* is nestled between *resources* and *motives*. Each element must be considered individually and then as the three interrelate; to do less is to fall short of *community* health. Health itself is partly, or maybe largely, a matter of applied knowledge. But applied knowledge, as any good extension worker can tell you, is a combination of resources, information, and motives.

Resources

We are talking about available, manageable, affordable resources—*available* in the sense that supply systems can be brought to bear on a long-term basis. Short-term changes are relatively easy to make, but if the supply system for the resources necessary to the planned health change are not available and cannot be made available on a long-term basis, the probability is that a cycle of frustration and despair will follow. The need for resources is one reason why missions today must pay more attention to the civil (governmental) health sector. Medical missions are not the only resource system we should be utilizing.

Manageability has to do with resources being managed in the long-term by people within communities. Permanent change in community health depends on systems that are manageable within the community context.

Affordability is the fit between costs and benefits, or more precisely, between the costs and secondary economic impacts of the particular resources that will be brought to bear in order to sustain a health improvement system.

Information

Three more terms are important here: meaningfulness, locality, and timeliness. Information has to come to people in ways they can understand in their own frame of reference and at their own levels of understanding. We make accommodations when communicating with people from our own culture. But it is harder to do cross-culturally. We tend to look down at people—to see them as inferior because they don't seem to understand. The real issues are the symbols, concepts, and logic of the people being dealt with. You must get into their frame of reference, or better yet, have the grace to allow national participation that determines timeliness and meaningfulness in *local* terms. Every situation is, in one way or another, unique; what works in one community just may not work in another community.

Timeliness has to do with a focus on interests and awareness of the community at a given moment. Information that comes at the wrong time is often useless. An information approach used to create awareness works fairly well with mass media where you can distribute your investment broadly. But if the delivery system is expensive, the messages had better be timely!

Motives

People operate not just on what they know but on what motivates them—or what they are emotionally involved with. Information that doesn't fit their motives will not be used.

Certain motives are always assumed. We assume, for example, that people want to be healthy and to have healthy children. We must look at this in terms that are real in the local motivational system, and to do so sometimes requires help. Our personal estimates and assumptions about motives (because of our Western orientation) can be distorted to the point where we see motives as individual rather than communal. In the majority world, "personal" matters, such as health, are more often communal than we are used to, but they are still personal. Majority world people identify more with their community than we do. One reason community-based approaches seem so senseless to us is that we cannot imagine people working together in a community or depending on community standards for personal habits. Yet, people in the majority world often cannot understand our notion of the individual. They cannot see individuals being deviant from the community.

Personalness has to do with the feelings of a person; but the person is a person in relation to a family and a community, not simply to a self-contained unit. Value changes that are to be induced by any educational program must somehow be disciplined by how the community values things.

In order to think seriously about community health, we must see community in a very large construct. First, we must see the linkages that tie local systems into larger systems and their pressures. On one hand, population creates pressures; on the other hand, political control creates pressure—as a kind of nest within which the community has to function and exist.

The Larger System

Many closely related issues fan out from the concept of health. If you are serious about health education, you have to raise questions about all those elements: water supplies, sanitation, agriculture, nutrition, medical services, and so on. Then questions must also be raised regarding political constraints or supports in each of these areas.

Community health education is serious business—often neglected. In my experience, medical people have tended to take a dim view of education. Their attitude is ironic, since, as a group, medical people have benefitted from lots of education. Medical people are survivors of

educational systems, and they are often disdainful of those who are not. They are highly motivated, compulsive, goal-oriented, and sometimes egocentric. Some of these traits may have been weeded out from medical missions, but in general, these traits persist in ways that can create problems.

The Inter-American Workshop in Community Education in La Paz in 1976 defined community education as "an informal education process which brings together all the people in a community, regardless of age or group membership, to discuss their problems and the resources available n the community for solving them."

Some of the more compulsive types of medical professionals tend to demean the notion of discussion. They fail to realize that communication is indispensable. If there is to be any development of human motive and meaningful sharing of knowledge, there must be discussion in the community. Support for community health grows as the people in the community make decisions and take responsibility for improving their own health.

For example, in the *Journal of Christian Medical Association of India*, (April) 1977, Dr. L.K. Ding asserted that community health is the total physical, mental, social well-being of individuals who have common organization or interests, or are living in the same place under the same laws. He then spelled out how that relates to the health educator's behavior:

1. Be willing to do to yourself what you wish others to do. People learn by example. A community health program cannot be inspired by sitting in an office. Others will follow suit until the offices are full of seated health workers.
2. Be flexible. Community health is a learning experience and all those involved must be willing to try new ideas and make mistakes.
3. Be prepared to learn from the community. They know what is acceptable and unacceptable in their daily lives. You must work and live within that framework, as well.
4. Be humble. Be willing to make mistakes, admit mistakes, and correct them.

In my opinion, the term "health education" should not be used interchangeably with "medical education." I suggest that, instead, health education be defined or limited to a concept of community-based learning systems, effectively dealing with health behavior. (The objectives are far more than conveying health or medical information; we are concerned with health behavior.)

The more one knows about community structure, and constraints in majority world contexts or community structures, the more complicated the problem of health appears. The humanitarian cries out, "Never mind the details, do something." But the experienced community analyst answers, "Doing something is to foolishly flirt with tragedy at worst, failure most probably, and chance success at best." Somewhere between the two extremes, the community health educator finds the more successful answers about what to do, based on decisions within the community. (The outside medical expert's sense of priorities may not always be fulfilled!) The community itself should be seen as a *resource*, not simply a place. The community is a body of thought, values, and behaviors. That body can work for or against health.

Three suggestions are offered in relation to community-level procedures:

1. S*ee the community positively*; avoid an adversary position. Sometimes the outsiders come in as saviors, take elitist postures, and make threatening proclamations. Instead, the approach should be accepting and compassionate—more empathetic than sympathetic.
2. *Move at a pace the community can handle*. Move steadily away from the "outsiderness" and "expertness" you bring in with you. Western health medical planners have their roots in complex technical systems, but the realities of the Third World are substantially different in obvious ways—in not-so-obvious ways!
3. The old logic of the "change agent" must be re-thought. Because, as Wisenburg from the University of Connecticut's School of Medicine reminds, "groups provide norms or expected standards of behavior. The deviant from those norms will lose group

membership. In a society where group membership is extremely important, we cannot single out individuals as lead change agents within the community" (In Simonds, 1976).

Julius Nyerere's influence is well known; history may show him to be even a greater force for good in the majority world than we currently acknowledge. It is important to understand his *Education for Self-Reliance* project. He used the whole nation as a mobilizing base for such things as health and literacy in the 1970 "Adult Education Year." If only Christian missionaries could understand the value of a national mobilization of the church in the same terms that Nyerere used with political mobilization.

Cooperation with national development programs is increasingly essential as missionary strategy. To ignore this maxim is to be out of step with the realities of a country. Sadly, some missionaries are inclined to feel persecuted when pushed to get in line with national development and health programs. The truth is that, like the student who blames the devil for a bad test score, we need to see that "persecution" often results from not having done our homework!

Following are three tentative principles for work with community health:

1. Know *when* to push the establishment of new community health programs. Try to get in step with local and national planning.
2. Realize the importance of training local health workers, preferably those selected and sponsored by local communities. The Lardin Gabas Project in northeastern Nigeria is a beautiful example of a project that trained simple local people in rudimentary concepts of health that could be disseminated within the community. The program called for the community to financially sponsor the trainees. The community, thus, then had a stake in the disseminators. They wanted something back for their investment—from their own people.

3. Bring information to bear on problems the community wants to deal with. I strongly recommend Paulo Freire's work. He speaks about "conscientization," a term that you should know in relation to the majority world. Freire's main point is that people learn as they act upon their own condition. Christians should have no trouble seeing his point: when a person claims to know but does not act on what he or she "knows," the knowledge is useless.

These principles and others are seen even more fully through the study of non-formal education. A brief look at this aspect of education can be useful.

Non-Formal Education

One way to define non-formal education is as specialized attention to the human development and social change factors that enable technological and modernizing technical assistance to succeed. In other words, highly focused.

In *Non-formal Education and Development*, Tim Simkins points out that much of our thinking about educating, training, and developing knowledge bases is cultivated from our formal educational traditions. Breaking loose from those formal traditions opens a new way of looking at community learning needs.

For example, consider a few rudimentary contrasts:

1. Formal education operates in long cycles and general goals; non-formal education operates in short cycles and specific objectives.
2. Formal education content is predetermined and often elitist; non-formal education content is output-centered, individualized, and functional.
3. Formal education is rigidly structured and teacher-centered; non-formal education is flexible and learner-centered.

Non-formal education uses more participatory project-method learning experiences. Non-formal education is designed to fulfill learning objectives for which there is functional need. The motive is to assure both effective and efficient learning outcomes through direct rather than indirect attacks or ignorance.

Ding's paper (above) summarizes five characteristics of community health that are well fulfilled through non-formal education:

1. Programs of community health are established through consultation with people (not brought in for the people from outside.)
2. Leaders of the community define programs, not medical leaders.
3. The most successful community health programs use local people to carry out much of the health work.
4. Programs include the mobilization of local resources as a major objective.
5. Programs see health as only one component of the overall community improvement system.

The experience of many literacy programs immediately following World War II provides insight into successful community-level programs. There were a number of dramatic successes. Some say that literacy spread rapidly, others disagree. It is quite possible that two different situations pertained because of differences in the communities' *need* to read. Re-working some of the data on literacy evaluation of the '50s and '60s should take into account a variable often ignored by evaluators: whether or not the community that engaged in the literacy program was a Christian community. I believe that methods have relatively less to do with literacy success than does motivation. For example, the "Laubach method" was used widely within Christian communities with consistent success. When it was used among other sorts of communities, it proved to be less successful. Surely, the motive to learn to read is more powerful than the particular methods. Motives for development and learning that arise out of the Gospel are apparently very strong.

As a Christian, I am motivated toward non-formal education for both health and literacy. I am concerned about the injustices that are created and perpetuated by elitist delivery systems. Along with John Stott, I opt for engagement with world needs, not escape. That engagement is best fulfilled through joint efforts within communities of Christians, not by bringing to them more and more preconceived, predigested learning packages based on outsiders' views of their needs.

Educational approaches that begin by telling people what they need to be or what they need to know are becoming more widely recognized as ineffective.

Our Lord's teachings on leadership, especially in the first 12 verses of Matthew 23, remind that we have no business treating others as if they were incapable of making decisions for themselves. Our Lord laid restrictions on his apostles that we should accept for ourselves; they are still appropriate in our time. Leadership, for the Christian, is servanthood. We must serve God's people—*among* God's people and *with* God's people.

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