CONCLUSIONS

225. This study is witness to the increasing legitimacy given by governments to health education. Almost all the countries in the Commonwealth have a health education section in, or attached to, the ministry of health. It is clear too that health education extends further than the ministry of health, to many other government sectors, and to non-governmental organisations. For all that, health education does not have high status, as reflected by the resources available for it and the numbers of professionals involved in it.

226. In the same way, community health education is accorded a place of some importance by health education units, but few are doing much **with** the community. For example, high priority is given to the production of materials which are usually used in classic situations: classrooms, outpatient clinics, or to specific target groups, with little community involvement.

227. This may in part be due to an underlying tension for many of those involved in health education. Promoting community health education may threaten institutional interests (local government, local landlords, industry and so on), and health educators may find themselves in difficult positions unless their own objectives are clearly worked out. There are also conflicts in relation to professional status: one school of health educators argues for greater professionalisation - for a group of specialists who are the co-ordinators, promoters and catalysts of health education activities. The other school sees health education as an integral part of all activities related to health, which should involve all health workers and also groups like teachers. In reality, most countries fall somewhere along the continuum between those two positions, having health education specialists at national and sometimes regional level part of whose job is to orientate other professionals towards health education.

228. Certain conclusions about community health education do emerge from our review of the literature and countries' responses.

229. First, community health education demands a decentralised approach, local control, and a great deal of consultation with local communities to determine **their** wants. The motivation of the community is all-important.

230. Second, community health education activities must be integrated with local health (and other) services, to ensure continuity. Involving primary health care workers is essential. One of the useful ways of doing this is through district or regional training seminars or workshops.

231. Third, health education units could look more widely at community activities outside government to see what is being done in the health education field.

232. Fourth, community health education activities must be carried out in the broad context of promotion as well as other community activities. This probably means campaigning at national level (to prohibit advertising of tobacco, prohibit smoking in public places, promote compulsory use of seat belts, encourage use of local foods, etc.).

233. Fifth, much more work could be done in evaluation and assessment of activities of health education units, both of particular projects and of priorities within the unit's programme of activities over time.

234. Sixth, more imagination could be used in bringing together different professionals for community health education activities. A multi-disciplinary approach can be a way of releasing extra energy.

235. Seventh, although mass media have their place, too much reliance on technology is not effective. Radio, in particular, has great potential, but allowances must be made for feedback through such mechanisms as listening groups. "Spots" are not good enough; there needs to be follow-up of the information relayed. Local language and life styles must be taken account of in the design of programmes.

236. Finally, much more could be done regionally, with more sharing of training facilities and exchange of ideas and experience. Workshops and seminars on resources, methods, strategies, and techniques in community health education could be a mutually stimulating way for Commonwealth countries in a particular region to expand their community health education activities.

RECOMMENDATIONS

237. From the analysis of countries' responses to the questionnaire and the survey of community health education we make the following recomendations for action.

National

238. Recognition should be given to the importance of community health education by establishing permanent planning arrangements between sectors, especially ministries of health and education, the media, and universities or other institutions of higher education.

239. At the same time, an attempt should be made to decentralise community health education activities, giving local communities as much say in decision-making about community health as possible.

240. The status of health education should be raised by improving resource inputs not only financially but also in terms of professional training for those involved in health education.

241. Serious consideration should be given to promotive action at national level in consultation with the tobacco, food and transport industries, for instance - to both improve community health and avoid the entrenchment of patterns of life that are known to contribute to a high risk of morbidity or mortality.

242. In view of the potentially deleterious effects on health of alcohol and tobacco, government policies regarding revenue from tobacco and alcohol (in particular) and their advertising and promotion through the mass media should be reviewed.

Regional

243. In order to stimulate interest and pool resources between Commonwealth countries, regional groups should discuss co-operation in community health education, using the medium of regional workshops for an initial exchange of ideas.

244. Regional universities and other educational institutions should publicise and exchange information on health education training courses to countries within the region, to establish more appropriate and effective collaboration in training for health education.

245. Regional workshops should be held on a regular basis to identify the scope of activities in national health information/education/promotion programmes with special reference to trends in communication through the mass media.

Commonwealth Secretariat

246. The Commonwealth Secretariat should, where possible, encourage discussion and exchange of information on community health education by:

(a) supporting regional workshops for those involved in community health education, both for professional health educators and for others working in education, media and relevant areas;

(b) providing technical assistance for such workshops where requested;

(c) providing scholarships or other financial assistance to individuals for further training where governments feel this appropriate.

247. The Commonwealth Secretariat should encourage governments to consider what promotive action can be taken on a national scale regarding tobacco and alcohol, food and transport, in order to improve community health.