"KARNATAKA MARCHES TOWARDS HEALTH PROMOTION IN 21ST CENTURY"

FOCUS ON HEALTH PROMOTION

"FEASIBILITY AND MODALITIES OF APPLICATION OF PRINCIPLES OF HEALTH PROMOTION AND ITS INTEGRATION WITH HEALTH EDUCATION"

BY

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CONTENTS

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Ref. No. : TFHFW / 261 / 2000 *Date*....14th Sept. 2000.....

To Whom So Ever It May Concern:

Dear Sir,

The Karnataka State Task Force on Health and Family Welfare is conducting a Action Research study on "A Proposal for Research Study on the feasibility and Modalities of application of principles of Health Promotion and its integration with Health Education". The research is conducted by Dr. K. Basappa.

I hereby request you to provide him with necessary information and access to data regarding the topic under study.

Thanking you,

With regards,

HSh.

(Dr. H. Sudarshan)
Chairman

INTERNATIONAL UNION FOR HEALTH PROMOTION AND EDUCATION (IUHPE) – SOUTH EAST ASIA REGIONAL BUREAU (SEARB) – KARNATAKA CHAPTER

ACKNOWLEDGEMENTS

International Union for Health Promotion and Education (IUHPE) – South East Asia Regional Bureau (SEARB) – Karnataka Chapter Sincerely thanks and appreciates the gesture of Karnataka Task Force on Health and Family Welfare for having invited the Chapter for conducting an action Research Study on "the feasibility and modalities of application of principles of Health Promotion and its integration with Health Education". The Chapter thanks Dr. H. Sudarshan, Chairman of the Task Force, Dr. C.M. Francis and other Members of the Task Force for their suggestions and guidance in completing the Research Study.

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Thanks of the Karnataka Chapter are also due to Dr. G.V. Nagaraj, Director of Health and Family Welfare Services, Dr. Kurthkoti, Additional Director (Health Education and Training) for their help and cooperation for organising the field visits to Districts, Primary Health Centres and Sub-Centers.

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Dr. K. BASAPPA
President
Karnataka Chapter-SEARB-IUHPE

PREFACE

Health promotion is defined a process of enabling people to increase control over the determinants of diseases and disability and improve their health by their own efforts.

The public policy and health policy in particular should be able to help people to acquire health and sustain it for a long time, so that they remain productive for more number of years and do not add to the burden f diseases and disability. Health promotional policy works in this direction.

The Task Force of Health and Family Welfare of Karnataka Government wanted to apply these principles into the Karnataka State Health Care Service. A rapid assessment of the State of art Health Education process was felt necessary and this report is related to the assessment of the extent and method of implementation of health promotion in Karnataka State Care System and to find out the modalities of application of the principles of health promotion with a view to integrate it with health education.

Topic

The topic is "Feasibility and modalities of application of principles of Health Promotion and its integration with Health Education.

The Process

The Research Team after receiving the orders of assignment from the Karnataka Task force on health and Family Welfare to take up rapid assessment of the existing situation with regard to the structure and functions of Health Education Wing of the State Health Department, prepared a research proposal and submitted to the Task Force. After approval of the same, the rapid assessment was taken up. The assessment involved:

1. Literature review on health promotion.
2. Field visits to 16 Primary Health Centers in 4 districts to know the state of art of health education activities and to assess the competencies of the health manpower at the district and Primary Health Centre levels and the organization strengths and weaknesses.
3. Obtained the views of senior health experts who were closely associated with the functioning of the Health Sector and present Health Education practitioners in and outside the State.
4. Some data were collected from the Health Directorate and District Health Officers about the structure and performance of the health education wing.
5. The data were analysed and discussed in the Seminar Organised for the purpose.
6. This is the final report of the assignment.

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SECTION – I

A. INTRODUCTION

B. OBJECTIVES

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Introduction and Objectives of the Study

A. INTRODUCTION

The Task Force on Health and Family Welfare, Government of Karnataka invited the Karnataka Chapter of the South East Asia Regional Bureau of the International Union for Health Promotion and Education to take up a rapid assessment of the "FEASIBILITY AND MODALITIES OF APPLICATION OF PRINCIPLES OF HEALTH PROMOTION AND THEIR INTEGRATION WITH HEALTH EDUCATION."

The Karnataka Chapter accepted the assignment and conducted the study. The following is the report of the study.

B. OBJECTIVES

1. To develop a vision and strategy statement on health promotion for the Karnataka State.
2. To examine the organizational structure and functions of Health Education Bureau of the Directorate of Health and Family Welfare Services.
3. To Make a rapid assessment of capabilities of health staff to undertake health promotional responsibilities with particular reference to competencies of grass root level health staff and their supervisors, block level health educators, District Health Education Officers, Medical Officers of Health of the Primary Health Centres and District Health and Family welfare officers.
4. To assess the existing inter-sectoral coordination related to health promotional activities amongst the different development departments and non-governmental organizations at primary Health Centre, District and State level.

C. MATERIALS AND METHODS

A qualitative assessment was decided upon because of the time constraint imposed by the task Force to complete the study. Though this is a qualitative study and based on focus interviews and observations, care has been taken to see that the interviews of relevant staff and observations have been made by the experienced researchers themselves to ensure credibility and validity of the report.

1. Literature about health promotion published in the International and National journals and WHO documents have been reviewed. It include global strategy for Health for All by the year 2000 and Alma Ata Declaration of 1978 on Health for all (H F A) 2000 and primary health care published by WHO and Ottawa Charter for health promotion (1986). And other documents and reports Reviewed are Report of an International Meeting on public Health (New challenges) and Ninth general Programme of work (9GPW) published by W H O.

2. Information about the structure and function of the Health Education Bureau were collected from the Directorate of Health and Family Welfare Services and the District Health and Family Welfare Offices of four District who are looking after planning and implementation of health programmes in their district. These information have been tabulated and analysed.

3. Date were also collected by interviews and from focus group discussions and field observations of the primary health centre and District Health staff regarding their competencies in health promotional activities.

4. Opinion of the health administrators, health researchers and health teachers on some aspects of health promotion and practice, its importance and feasibility and the competencies and skills required to implement health promotional strategies have been collected by open-ended questionnaire and analysed. Experts from the State of Karnataka and outside the state were included in the study.

5. For field study one district from each of the four revenue divisions of the State was selected. Sixteen Primary Health Centres, 4 from each district were selected for observational study. The district are kolar from Bangalore Division, Bijapur from Belgaum Division, Bellary from Gulbarga Division and Kodagu from Mysore Division.

6. In order to know the existence and extent of intersectoral coordination and cooperation and involvement, representatives of various development

departments and non-government organizations were also included in the study.

7. Criteria used for assessing the competencies and skill of the staff of implement health promotional activities and opinion of Public Health Experts.

Criteria Used			Rank Assigned
	KNOWLEDGE		
1.	Has a clear perception of the meaning of health promotion. His/her job responsibility and that of health department	...	High
2.	Has vague perception	...	Moderate
3.	Has no perception	...	Low
	ATTITUDE		
1.	He/she is very eager to promote health promotion work.	...	High
2.	He/she feels that it is worthwhile, but shows indifference and not so enthusiastic about their job.	...	Moderate
3.	He/she feels rather not concerned about his job responsibility and about health promotion or health education	...	Low
4.	OPINION ON STATEMENS		
	Strongly Agree	...	Consenses
	Agree	...	Exist
	Agree with reservation	...	Consenses
	Disagree	...	Does not exist

STATEMENTS MADE ARE RELATED TO THE FOLLOWING.

1. Need for health promotion and Education.
2. Methods of planning health promotional activities.
3. Importance of social mobilisation activities.
4. Need for involving people in the health programmes.
5. Need for inter-action with developmental departments and non-governmental organizations.
6. Need for further training of health staff.
7. Additional training for Medical Officers of Primary Health Centres.
8. Need for re-orientation of syllabus in Community Medicine in MBBS and MD courses.
9. Need for change in the attitude of policy makers towards public health and health promotion.

TABLE – 1

STATEMENT SHOWING THE NUMBER OF RESPONDANTS WITH THEIR DESIGNATION, PLANNED AND CONTACTED

Sl. No.	Designation	Number Planned	No. Contacted
1.	Director of Health and Family Welfare Service	1	1
2.	Additional Directors of Health & FW Services	4	3
3.	Joint Directors of Health of FW Services	6	6
4.	District Health and Family Welfare Services	4	4
5.	District Health Education Officers	4	4
6.	Dy. District Health Education Officers Block Level Health Educates	20	14
7.	Medical Officers of Health of Primary Health Centres	16	12
8.	Health Supervisors, Male and Female	32	28
9.	Health Workers Male and Female (ANMs & Jr. H. Asst.)	64	50
10.	Health experts and senior Health Administrators	98	48
11.	Non-Govt. Organizations	8	6
12.	Other Government Sector representatives		
	1) Education	1	1
	2) Public Health Engineering	1	1
	3) Agriculture	1	1
	4) Horticulture	1	1
	5) Women and Child Welfare	1	1
	6) Information and Publicity	1	1
		262	182

SECTION – II

NEED FOR HEALTH PROMOTION

According to World Health Organization the definition of Health is "a state of complete physical mental and social well-being and not merely the absence of disease". Despite this definition and its widespread usage, all over the world large majority of people view the health in the context of curative medicine, often described perhaps presumptually – as "modern scientific medicine". Apart from this, there is a pervasive misconception among health planners in many countries especially in developing countries that good health is primarily a result of medical intervention and hospital services and there has been a growing morginalisation of public health.

NEW CHALLENGES

But the evidence available is quite the contrary. Makeown's research has shown that past improvement in health has been due mainly to modification of behaviour and changes in the environment. For example, Mckepwn's analysis of mortality trends in U.K. between 1801 – 1971 has shown that mortality from infectious diseases such as Tuberculosis, Bronchitis, Pneumonia, Influenza etc., as well as from water borne and food borne diseases had already begun to decline even before effective treatment became available.(1)

(1) Mckeown suggests that communities and Government should look into factors (behavioural and environment) to bring further advance in health status of their countries.

(2) Studies have also shown that extreme poverty of some $1/5^{th}$ of the world population is the greatest killer and largest cause of human suffering Disparity in health exists between nations and the gap is increasing Healthier countries are becoming more healthier and poor health countries are becoming poorer in health status. Just like rich countries becoming rich and poor countries becoming poor due to imbalance in the economic development.(2)

(3) In addition, grave disparities in health condition remain within the countries, communities and gender. For example poorer and less educated people suffer from higher mortality and morbidity than those who are better educated and have higher income within the country and communities.

Women carry the triple risk of death and disease because of reproductive burden and gender inequality and social injustice in all walks of life. Therefore, people who are relatively poorer, less educated and women living in rural and semiurban and slums of big cities have less access to health care system, suffer more from inequality and social injustice. (2)

(4) The emerging fourth challenge is the resurgence of old diseases like Malaria and Tuberculosis and new diseases like HIV/AIDS and drug resistance of insects and bacteria are all adding to the problem of health of developing countries. (2)

(5) The fifth challenge causing alarming situation both in developing and developed countries is the increased cost of medical care due to social and commercialization of medicine, in the advent of advanced diagnostic and technological knowledge. Inspite of these advances and costly treatment, there has been no improvement of health of the people in relation to expenditure. (2)

(6) The 6th factor causing concern is related to alcoholism, drug addiction, tobacco smoking and tobacco chewing.

In the face of these challenges, the approach and strategy for maintaining and improving the health of the people should concentrate more on the root cause of illhealth and diseases. These root causes or determinants of health and diseases are related to (1) income (2) Education (3) Employment (4) Nutrition (5) Housing (6) Safe Water (7) Sanitation (8) Health environment (9) Health care infrastructure (10) People's participation (11) People's awareness, and level of skill (12) Primary health care (13) Prompt diagnostic and therapeutic services and (14) Rehabilitation services. these are the direct cause. The indirect cause are many and they prevail in all walks of life of governance. Some of them, are public policy health policy in particular, right to health, access to health care infrastructure and quality of health care providers, equity and social justice etc.

In these circumstances people's health can be improved and sustained only by comprehensive plan of action that cuts all roots and rootlets that cause illhealth. For this to happen, all the people and the concerned government organizations, voluntary organizations and religious organizations, Industries should come together and work at all levels from the top policy makes (political, social and religious leaders) to people's representatives.

HEALTH PROMOTION

What is Health Promotion?

Health Promotion is defined broadly as a process of enabling people to increase control over the determinants of illhealth and improve their health. In essence, health promotion is Social and Political action. It seeks to empower people with knowledge and understanding of health (health education) and creating conditions conducive to healthy living and healthy life style (social support). It reaches and involves people through the context of their every day lives, such as homes, work places (Industries, offices) learning (schools and colleges), and play ground recreation facilities, and eating establishment.

Health promotion takes a developmental approach to health, whereby health is considered as the goal and is a result of the activities of all development sectors like housing, local governments, education, industry, agriculture, transport services etc. Development approach promotes stronger health programmes characterized by greater relevance to various development sectors such as school health, healthy cities, healthy villages, and healthy food markets etc.(3)

In her opening address to the 5th global conference on health promotion in Mexico Dr. Gro Herlem Brundtland, Director General, World Health Organization stated that "Promoting health is about enabling people to keep their minds and bodies in optimal condition for as long as possible. That means, that people know how to keep healthy. It means that they have the power to make healthy decision – within them selves, community, local government and within the State. (4)

The UNICEF "State of Health of World's Children – 2000" (5) presents evidence to show that India is not investing sufficiently in mother and child care despite the fact that infant mortality rate and under 5 mortality rate are not showing any decline in 2000 as compared to 1998-99.

II. OTTAWA CHARTER AND JAKARTA DECLARATION ON HEALTH PROMOTION

Significant features of the Charter

1. Ottawa charter define health promotion as a process of enabling people to increase control over the determinants of illhealth and to improve their health.

2. Health is seen a resource for every day life and not objective of living.

3. Health promotion is not just securing of health, but goes beyond healthy life styles to well-being.

4. Pre-requisite for health are: (1) income (2) food (3)shelter (4) sustainable resources (5) social justice (6) equity (7) water supply and sanitation(8) education. Improvement in health requires a solid and secure foundation in all these basic needs.

5. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or may be harmful to it. Health promotion action aims at making these conditions favourable to health through advocacy.

6. Health improvements require secure foundation in (1) a supportive environment (2) access to information (3) development of life skills and opportunities for making healthy choices (4) equal opportunities for all segment of the population to het free access to health and related services irrespective of class, creed and gender difference. Health promotion aims at enabling people to take control of those things which derermine health.

7. Health pre-requites and health supportive accessories cannot be ensured by health sector alone. It demands coordinated action by all concerned, by governments, health and other social and economic sectors, by non-governmental and voluntary organizations, by local authorities, local communities, families and individuals. Health promotion action aims at bringing coordination between various sections and media, between differing intersts in society for the pursuit of health.

Based on the above principles, the Ottawa Charter suggested the following action.

1. Build Healthy Public Policy

The health promotion agenda of the makers in all sectors, at all levels of government and society directs them to be aware of consequences of their decisions and accept their responsibility towards health. Health promotion policy combines diverse, but complementary approaches like (1) legislation (2) fiscal measures (3) taxation and (4) organizational changes. It is the coordinated action that increases income, foster greater equity and social justice to individual family that counts to improve health. The health promotion policy requires the identification of obstacles to the adoption of healthy public policy in both health and non-health sectors and finds ways and means to remove them and thus helps policy makers to make healthier choice.

2. Create supporitive environment

Creation of an environment supportive and sustainable is a prerequisite for health. Intricate links exist between people's health and their environment and this is the basis of socio-ecological approach to health. While conservation of natural resources should be encouraged through out the world as a global responsibility, the modification and creation of sustainable new resources for health should be the responsibility of every nation and every community.

Supportive environment consists of two components. One is the physical environment and the second is the social environment. As for as physical environment is concerned, that every person and family must have work and minimum income to possess and utilize the infrastructure. The way society organizes work would help to create a healthy environment. Health promotion should generate living and working conditions that are safe, stimulating, satisfying and enjoyable.

Social environment is concerned with changing old behavior pattern or adoption of new behavior pattern is of course possible only when man or woman is motivated and committed to behavior change. But the process of motivation and commitment can be made easier and quicker by creating social environment which creates critical mass in the community. That is the opinion of family, peer groups, formal and informal leaders and religious groups

should support a particular behaviour. It may be about small family norm, giving up tobacco and alcohol, extramarital sex or age at marriage ect.

These health promotion activities help to create and sustain such social pressure. The concept of supportive environment implies that action is oriented towards determinants of the health of the population. This is used to build bridges between sectors and professions, between theoretical concepts and practical action for an improved countries,

Achieving supportive environment will require a new awareness of the possibilities for improving health through environmental change. It will also require a strong future orientation that links public health to sustainable development and consequently require a new emphasis on strategic planning and development of management skills to facilitate cooperation between sectors.

3. Strengthen community action

Community action play a very significant role in making people believe in what they do and how they do and behave. It cements their belief. Therefore, community action programme, where they plan, take decisions, implement them, mobilizing their own resources and take control over and won them should be encouraged. Community development draws on existing human and material resources in the community to enhance self help and social support and to develop flexible systems for strengthening public participation and direction of health matters. This requires, full and continuous access to information, learning opportunities for health as well as funding support.

4. Develop personal skills

Education for health and enhancing life skill development are important, because they increase the options available for them to exercise more control over their own health and their environment, which sustains health. Enabling people to learn through out their lives, to prepare them for all stages of life and cope with the illness and injuries are essential. This has to be facilitated in schools (school health) home, work place (occupational health) and community setting. Health promotional activities extends to these areas through educational, professional commercial and voluntary bodies,

5. Reorient health services

Health sector and health professionals remains the sheet anchor of health promotion. they must plan efficient system of primary health care service through out the country from villages to metropolitan cities. They must involve local governments and people to take control of them. They must move increasingly in a health promotional direction beyond clinical and curative services. Health sector and health professional need to embrace and expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of the individual and communities for a healthier life and open channels of communication between the health sector and broader social, political, economic and environment components. The health sector and other sector of government, voluntary health organizations and other groups in the community must work together and contribute to the pursuit of health.

Jakarta Declaration on Health Promotion into the 21st century.

The Jakarta Declaration on health promotion offers a vision and focus for health promotion into the 21st century. Its main emphasis is to tackle health determinants and for this, it draws upon widest range of resources from all sides. The declaration recognizes that health promotion is an essential element for health development. Health promotion, through its investments and actions on determinants of health, contributes significantly for the reduction f inequalities in health, ensure human rights and build social capital which is so important for health and well-being of people . The ultimate goal of health promotion, as envisaged in the declaration is to increase in the health expectancy and to narrow the gap in health expectancy.

The Jakarta declaration endorses all the five Ottawa Charter Strategies

Charter strategies:

- Build healthy public policy
- Create supportive environment
- Strengthen community action
- Develop personal skills
- Reorient health services

In addition, the following five priorities for health promotion have been suggested.

- Promote social responsibility for health of decision makers.
- Increase investments for health development
- Consolidate and expand partnership for health
- Increase community capacity and empower the individual
- Secure an infrastructure for health promotion.

The Declaration calls for action to speed up progress towards health promotion giving priorities for the following:

1. Raising awareness about the changing determinants of health.
2. Supporting the development of collaboration and networks for health development.
3. Mobilisation of resources for health promotion.
4. Accumulating knowledge on best practices.
5. Enabling shared learning.
6. Promoting solidarity in action.
7. Festering transparency and public accountability in health promotion.

Jakarta declaration called on W.H.O. to take the lead in building a global health promotion alliance and enabling its member States to implement the action programmes. A key part of this role is for W.H.O. to engage governments, non-governmental organizations, development banks, U.N. agencies, inter-regional bodies, bilateral agencies, the labour movement and cooperative as well as private sector in advancing the action priorities for health promotion.

III. HEALTH EDUCATION

The widely used definition of health education is "Health Education is a process which affects change in the health practices of people and in the knowledge and attitudes related to such changes". (6). This definition implies that health education is a process, it involves series of steps, it is concerned with establishing changes in knowledge, attitude and behavior and also involves efforts by the people. Aims of health education as formulated by W.H.O. (7) is to (1) ensure that health as a valued asset to the community (2) equip people with skills, knowledge

and attitude to enable them solve their health problems by their won efforts and (3) to promote the development and proper use of health services.

Health education in the context of health promotion concept.

According to a position paper on health education jointly prepared by International Union for Hygiene Education and division of health education W.H.O. Geneva – with support from Centre for communicable diseases Control U.S.A. (8), health education is the combination of planned social action and learning experiences designed to enable people to gain control over the determinants of health and health behaviors and the health status of others.

Planning

1. Planning must be based on the consideration of relevant information. This information must provide multiple factors that influence the behavior and health related outcomes of interest and must account for the needs of interests of the target people.

2. The people who use this data must be knowledgeable in isolating those factors that affect health and also must possess skills to determine the relative importance of these factors.

3. To ensure the needs and interest of the target population, they must be involved in the planning process.

4. People's participation assures that there is a rapport with people and a basis for pursuing mutual efforts and partnership. It should be characterized as doing something "with" rather than "to" the people.

5. Health programmes are more successful when target population perceive the problem and solution in question to be the most important and appropriate respectively. People are found to act on issues they judge to be important them.

6. Creating demand for health is an important responsibility of health education. For example, people may not judge a given problem or issue to be important simply because they are unaware of its magnitude or prospective and long-term effects.

Learning experiences

1. Numerous factors influence the learning process including literacy, access to services and media resources, readiness for change health beliefs, environmental and social barriers and social reinforcement. Therefore, the health education programme planning must take into consideration not only for technical education barriers such as illiteracy, but also for social and economic barriers.
2. There are difference in the way people receive, process and act on information. So health education programme must be prepared to offer a variety of learning methods and strategies to maximize the probability of attaining the desired educational and behavioral outcomes and necessary social change.
3. Combination of health education methods are important in effective communication. This depends upon the characteristics of the target population, active involvement of collaborating organizations and representatives of the community as partners, availability of resources and competence of the persons conducting the health education programme.
4. There is no single model or method that holds universal superiority, health education specialists, must understand a variety of educational, behavioral and social sciences theories.
5. Those who plan health education programmes must be capable of adopting educational strategies for various sub populations of the community of the basis of characteristics that may be practically identified, such as age, sex, neighborhood, ethnic and cultural identity
6. Therefore, the older concept of health education is not sufficient to meet the needs of health promotional goals. It should strive to enable people to identify the determinants of health and take action to nullify their effects on health and take control over the measures to protect, preserve and promote health. The task of improving health is not only confined to health sector, health professionals and health communicators, but to all developmental sectors of government and non-government organizations, religious leaders, traders, industrialists, politicians and all those concerned with governance of the county and who matters for running the country towards development, progress, and happiness.

Health sector, health professionals and health communicators have a special role to play. They should act as coordinators, advocates and facilitators of health promotion.

Action required for individual countries or states with in the countries for health promotion.

In order to provide action plan for promotion of health in developing countries, W.H.O. Working Group on Health Promotion convened a meeting of senior health administrators in the region in 1989. The group identified the following areas for action.

1. Enhancing health knowledge and understanding is the first essential step in health supportive action by people.
2. Creating conditions – (social and environmental) that are conductive for health is another essential requirement.
3. These can become a reality when there is high level of awareness for health among policy makers, politicians, economic planners Health Researches, and the public people.

When the awareness is transferred into policies and legislative support, favorable resource allocation for health would follow. Thus full mobilization of all social forces for health will be needed for health promotion. In order to achieve these goals, three fold strategies are recommended. They are (1) Advocacy (2) Social and Environmental support for health and (3) Empowerment of people for health.

Brief description of Advocacy Social Support and empowerment.

1. Advocacy:

Advocacy is the process of providing evidence based knowledge to people so that they become convinced and committed and take appropriate decision in favor of the action required. Thus Advocacy is helpful in generating public demand and bring about health issues in every day activities. It helps policy makers and elected representatives to make right kind of decisions in the allocation of financial resources for community health. It helps religious leaders to become more committed and convinced and help spread scientific way of life to the people. It convinces political leaders to realize the need for support people's wishes and try to reorient health system. Advocacy to professional people helps in creating motivation and interest in researching problems that affect people's health and find scientifically based strategies to solve health problems. Finally Advocacy helps create critical mass of interest and support positive health and makes people to take healthier decisions.

Social support for health

Social support means creating and mobilizing favourable public opinion in favour of health behaviour. This helps in legitimization of a particular action. It may be small family norm, giving up smoking or giving unhealthy habits and take decision to build a sanitary latrine in the house. Public organizations and institutions like, Youth Clubs, Mahila Madals, Panchayats and other social groups, are very usefull in these matter.

Building health infrastructure in villages and towns and cities is another social support system. Health infrastructure like (1) protected water supply (2) sanitation and sewerage system (3) building health centers and hospitals within the easy reach of the people and (4) provision of good roads and transport etc.

Empowerment of people for better health

Empowerment of people means, providing health literacy and spread of knowledge to all and motivate and create interest in them so that every body become self-supporting in health. Inculcation of knowledge and helping people to develop required skill and capacity to acquire positive health and maintain it. It includes suitable employment to every body equitable access to health, infrastructure and health advise and health care services.

Thus favourable decisions of policy makers and those who allocate resources at the State and Central levels are crucial. Followed by proper planning, strategy, development for health promotional activities at State and District level are essential. Directorate of Public Health must have adequate manpower and resources to implement the programmes effectively and monitor and evaluate and provide feedback to the programme managers. In addition, the people should participate in planning, implementation and management of health programmes at participate in planning, implementation and management of health programmes at grass root level in every village, town and city if health promotion is to become a reality.

Factors which determine health status of the population and main actors responsible – An Overview

1. Individuals, Family and the Communities.
2. Local, District and State level government health Organization.
3. Sectors other than health.
4. Central Government.

HEALTH DETERMINANTS THAT NEED ATTENTION

1. Individuals Family and Community

While genetics cannot be changed, the person's awareness, knowledge, skill life style play an important role. Family decides the way of living, nutrition standards, home environment. Family also decides about education, how many children are wanted, handle family conflicts, how to care for disabled members. The community influence the health of its members through safe water supply, sanitation, education, shelter, handling violence and un-employment.

2. Health Ministry (State) Health System Services, Health research community.

Health Ministry and health professionals are responsible for:

a. Health legislation.

b. Health policies and budgeting.

c. Health education.

d. Provide primary and secondary health care.

e. Make available minimum health care facility accessible for all.

f. Administer and manage health care facility so that the services are actually rendered on day to day basis.

g. Develop and maintain research health planning, monitoring health programme, implementation and determining health impact of health programmes and to provide needed evidence to the policy makers and allocation of health resources.

h. Training and maintaining pool of medical and health personal of various levels of expertise, health administration etc.

3. Sectors other than health
    1. Government Sector.
    2. Non-Govt. Sectors.

Almost all sectors of economic activity have an impact on health status of the community through national or regional policies and decisions. For example Farm and Food Policies have a direct impact on health so also water supply and sanitation and primary education, environmental pollution and degradation due to uncontrolled industrial pollution have indirect impact.

Social security system for working people and senior citizens, level of employment, control of criminality and violence have indirect effect.

Rural and urban development, housing industry, energy and transport sectors have both direct and indirect effect on health the effectiveness and efficiency of administration and also measures to limit corruption have additional impact on community health.

4. Central Government

Although Central Government is far away from health situation of the individual, the macro economic policies of the government and principles of good governance in general both have a direct impact on health. Economic policies and the allocation of budget between the various ministries, the degree of commitment of the ministries for their missions, the efficiency and effectiveness of administration and the research policies pursued by the government have all impact on health problems.

Health Promotion and its benefits

A. Benefits from the Control of ENVIRONMENT

Experience of the western countries is striking to demonstrate the vast benefits of health promotional activities (action on the root causes) that accrue to mankind. These countries brought down infant mortality rate from 200/1000 in 1880 to about 70 by 1930. The morbidity and morality due to gastro-intestinal disease came down markedly during the same period 60 to 70% of these improvements are attributable to safe water supply and provision of sanitation, good housing Nutrition, education and behaviour changes like personal hygiene and practice of small family norm by majority of the people in those countries.

India missed Industrial Revolution so also Sanitary revolution that brought vast improvements in the standards of health of Western Countries. India under the foreign rule for over 200 years, with its deep entrenchment in tradition, superstition etc. is still even in the wake of 21st century and independence is experiencing the vary high preventable mortality, morbidity and disability. This is because, very little attempts have been made, to act on the root causes of illhealth. Even in the 21st century, nearly 40 to 45% of people do not have water supply (70% do not have safe water supply) 65% do not have toilet facilities, 40% of women between 15-49 years suffer from preventable anemia and 35 to 38% of women have body mass index below 18.5 kg/m, and 44% of children under 3 years are underweight. These are the examples to show how the country's health system is neglecting the health promotion activities. The experience of the western countries who are implementing some of the health promotional programmes in their communities against chronic and behaviour related disease shown substantial improvements in health of the population besides brining down the burden of disease and social costs.

The evidence that health promotional policies and actions yield substantial health benefits is being accumulated.

B. Benefits from behaviour modifications

1. School Health

School health programmes for promoting better health show clear evidence of achieving higher literacy levels, reductions in dropout rates, cassation of smoking, reduction in substance abuse, reduction in social consequences of teenage pregnancy. School health promotional programmes can be effective in transmitting knowledge, developing skill and supporting positive health choices. The evidence

mortality from coronary heart diseases, 11% less from cancer mortality. Among pregnant women smokers cessation of smoking has resulted in lowering the risk of low birth weight and reduction of obstetric complications. Smoking cessation is found to most cost effective programme. The cost per life year gained from such programmes ranged from 2000 to 5700 US $, where as the cost per year gained from treatment for mild hypertension is up to 8600, and the cost of extensive drug treatment per life year gained is more than 192,000 US $.

4. Mental Health and health promotional activities.

There is significant evidence to show that mental health promotion strategies have reduced depression, reduced suicide rates and reduced behavioural problems. Swedish Educational Programme have shown very positive results. For example, there was reduction of suicide rates for 19.7 cases/100000 population to 7.1 cases after 3 years of programme implementation. Besides there was economic benefit, the number of inpatient days reduced by 70% and there was also savings in the amount of tranquilizers and anti-depressant drugs used. Other mental health promotional programmes have reduced teenage pregnancy HIV infections, 75% reduction in pre-term delivery, reduction in low birth weight babies and babies with brain damage.

5. Healthy Ageing

The real key to healthy ageing is to begin health promotion early in life. However, there is evidence to show that application of health promotional activities like, physical activity even at the age of 50 can bring down substantially cardiovascular mortality and risk of falls and enhances cognitive function of the mind. The impact on society is seen in keeping the elderly population active and therefore productive for a longer period, reducing health and social costs. The available evidence show that maintaining healthy life styles in old age is directly associated with health gain.

6. Healthy Equity

Equity is health is gaining ground in recent years. WHO describes equity as a fair opportunity provided for all people to enjoy health to their fullest potential. It does not mean equal health status for every one, but it means reduction of differences between people's health as much as possible through equal opportunity for health. There is evidence to show that socio-economic conditions related to income, education and employment are at the root causes of illhealth. Even in Europe, substantial number of people (57 million in 1993) lived in 23 million poor

households. Even in rich countries, people with means live several years longer and have fewer diseases and disability than people without resources.

Relative deprivation has show to have profound effect on healthy rather than absolute poverty. Relative deprivation can have poorer education, low skill development, higher unemployment and lower capacity to deal with information and lower material resources. There is strong evidence to show that relative poverty is closely linked to poorer health. Many equity interventions for health are found to have impact at community level. People can gain increases ability to solve their problems at every stage of participation or involvement of the local community.

Healthy cities concept of WHO's Health for All strategy with hundreds of people participating provides a strong multi-agency framework for development. Such programmes have shown evidence of effectiveness including generating increased income, through work opportunities improved community support with counseling services and better community involvement etc.

Data also show that health and education are most important and powerful forces for economic development in poorer countries. Basic investment in health and education can produce positive economic outcomes. This kind of investment in Trinidad, Cuba, Chile and Cost Rica has reduced poverty to less than 10% of the population.

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SECTION – III

Health Education Bureau

1. Introduction and objectives
2. Structure of Section I
3. Structure of Section II
4. Functions of Section I
5. Functions of Section II
6. Recommendations

I. HEALTH EDUCATION BUREAU

1. Introduction and objectives

The State Health Education Bureau (SHEB) was started in the Directorates of Health and Family Welfare Services in the year 1930. The Bureau was reorganised in 1965 with the assistance of Government of India, W.H.O. and UNICEF. Stewarts like Dr. V. Ramakrishna and others played a significant role in bringing about the establishment of the SHEB in the Department of Public Health in the Mysore State. It was nurtured and enriched by many eminent Directors of Public Health of Mysore State and latter Karnataka State ever since. World Health Organization, Rocke-feller Foundation and other International Health Organisations also helped the growth of the State Health Education Bureau.

The Bureau developed a sound health education policy for the state and exerted its influence in improving the health status THROUGH HEALTH EDUCATION. The Bureau laid down long term and short term objectives, structure and functions needed to reach those objectives.

A. Long term objectives

a. To help people to achieve health by their own actions and efforts.

b. To obtain people's active support and participation for public health programmes and policies.

c. To assist people to shoulder the responsibility for health.

d. To encourage people to demand more and better health services.

B. Short term objectives

a. To collect baseline data of the prevailing health conditions, health attitude, beliefs and values etc.

b. To educate the people on health matters by various methods and evaluate the relative effectiveness of the methods and channels of communication.

c. To provide in-service training in health education for all categories of health staff.

d. To produce health education materials and reproduce them wherever needed.

To reach the above objectives, the Bureau laid down the following activities.

1. Planning, organising and directing State-wide health education activities.

2. Conducting studies regarding baseline data, health educational needs, resources, priorities etc.

3. Determine the appropriate channels of communication and develop effective methods and materials for their use.

4. Training of the personnel of health and family Welfare Department on health education methods.

5. Assisting, organising and conducting of seminars conferences, family group teaching etc.

6. Fostering cordial intra and inter-departmental coordination and building group relationship with non-governmental organizations.

7. Dissemination of scientific information for people, through various channels of communication.

II. STRUCTURE AND FUNCTIONS

A. STRUCTURE OF THE HEALTH BUREAU – I

The State Health Education Bureau consists of two Divisions. First Division is headed by the Project Director, Reproductive and Child Health Services and Second Division is headed by the Additional Director, Health Education and Training. Functionally also the first Division is concentrating on health and family welfare and the second Division is concentrating on School Health, Training Nutrition etc.

Sl. No.	Categories	Sanctioned	Working
	At State Level		
1.	Joint Director	1	1
2.	Deputy Director	2	1
3.	Field Publicity Officer	1	--
4.	Editor	1	1
5.	Assistant Editors	2	--
6.	Health Education Officer	1	1
7.	Health Educator	1	--
8.	Social Scientist	1	--
	At the District Level		
1.	District Primary Health Centre Level	31	7
2.	Dy. Dist. Health Education Officers	104	78
	At the Primary Health Centre Level		
1.	Block Health Educators	782	517

Health Educators with Diploma in Health Education (DHE)

	No. with DHE	No. without DHE	Total
State Level	10	--	10
District Level	130	5	135
Pry. Health Centre	51	466	517
Teaching Staff	26	--	26
Total	217	471	688

Comments

The strength of the staff and their qualifications at the State Level is adequate, but the vacant posts should be filled up.

At the district level, 104 posts have been sanctioned for 27 districts at the rate of more than 3 per district. Whereas, only 782 posts of Block level Health Educators have been sanctioned for 1685 Primary Health Centres. At the rate of one Block Level Health Educator per primary Health Centre, still 903 posts are to be created. This is very difficult to achieve in the near future, because, it involves heavy expenditure and no trained and qualified Health Educators are available for recruitment.

Besides taluka level health officer posts which are sanctioned recently to strengthen the administration and management of health programmes in rural areas. This is a good development and this taluk level health office should be strengthened with posts of Health educators. Therefore, there is need to reorganise the distribution of available Block Level Health Educators between talukas and PHCs.

STRUCTURE OF THE HEALTH EDUCATION BUREAU – II

This action of State Health Education Bureau consists of the following staff.

Sl No.	Category	Sanctioned	Working
1.	Additional Director	1	1
2.	Joint Director	1	(vacant)
3.	Training Unit		
	1. Training Officer	1	1
	2. Health Supervisor	1	1
4.	Student Health Education Unit		
	1. Deputy Director	1	1
	2. Assistant Director	1	v
	3. Dist. Nursing Officer	1	1
5.	Audio-Visual Unit		
	1. Technical Officer	1	v
	2. Artist cum-photographer	1	v
	3. Artist	1	v
	4. Sub-Editor	1	1
	5. Projectionist	1	1
	6. Craftsman	1	v
	7. Silk-Screen Technician	1	v
6.	Field Study & Demonstration Unit		
	1. Technical Officer	1	v
	2. Health Supervisor	1	v
	3. Public Health Nurse	1	1
	4. Home Science Assistant	1	1
	5. Social Scientist	1	1
	6. Teacher	1	1
7.	Exhibition Unit		
	1. Technical Officer	1	v

FUNCTIONS

A. INTRODUCTION

The main function of the Division I of Health Education Bureau is to plan, implement and monitor health education activities pertaining to family welfare in rural areas of the State. These activities are implemented and monitored through the District Health and Family Welfare Officer at the District level and Medical Officers of Health at the Primary Health Centre level under the over all supervision and control of respective Zilla Panchayats. The bulk of the work is carried out by the grass root level workers and Health Supervisers. Block level local non-government organisations and public people. He also guides Health Workers and Supervisers and monitors the health education activities.

At the district level, the District Health Education Officer prepares a district plan of IEC activities. He supervises and monitors all health education activities throughout the district. He under takes tours and meet and discuss the health education issues with other developmental sectors of the government and local non-government organizations. He is also resource person for local Non-Government Organisations for health education activities.

B. OBJECTIVES, STRATEGIES AND METHODS USED FOR THE IEC ACTIVITIES.

a. Objectives:

1. Promotion of higher age at marriage.
2. Promotion of spacing methods.
3. Promotion of terminal methods for those who are having more than two children.
4. Involving people in IEC activities.
5. Motivating people to demand Reproductive and child health services.
6. Encouraging people's participation.
7. Discouraging gender discrimination with respect to conception and child care.
8. Encouraging 100% ante-natal registration and care.
9. Motivating and encouraging parents to care for infants and under 5 children especially in the matter of nutrition and immunization.

b. Strategies used for IEC activities

Most of the IEC activities are 100% centrally funded and sponsored. They are planned at the State level as per guidelines given by the Government of India and given to the districts for implementation, monitoring and reporting. The number of activities and methods to be used are fixed depending upon the total grants received. At the district level, the number of IEC activities are divided among several Primary Health Centres in the district and given to the Medical Officers of Health for implementation.

c. Method used

All the standard methods of health education are used. They are:

a. Mass media, Door Darshan, Radio, Press, Video Films.

b. Folk media – Dramas and street plays.

c. Exhibition.

d. Personal communication by grass root level workers.

e. Group discussions:

1. Mother Swasthya Sangha (MSS)
2. Atte Sose Samvada
3. Village Health Committee
4. Village Panchayat
5. Local S.H.G. and youth and Yuvathi Mandals

TABLE – 2

Number of IEC activities by conducted in the last 3 years

		Targeted & achievement during the last 3 years 1997, 1998 & 1999		
Sl No.	**IEC activity**	**Target**	**Achievement**	**% of achievement**
1.	Film Shows	14400	6198	43
2.	Film Strips	40500	40204	99
3.	TV & VCB	4050	2500	99
4.	Folk media programme	2700	2500	90
5.	Multi-media campign	-Nil-	169	--
6.	Press advertisements	-Nil-	979	--
7.	Press release	-Nil-	4273	--
8.	Exhibition – major	14400	5390	37.3
9.	Dramas	--	32	--
10.	Healthy Baby shows	10735	9222	86
11.	Mahila Vichara Vinimaya	12615	9770	77
12.	Mother-in-law and Daughter-in-law program	8545	6921	81
13.	Mahila Dinacharini	6320	5073	80
14.	MSS Workshops: Taluka	175	160	90
	District	9	9	100
15.	Folk Artist Workshop (1997)	19	8	
16.	Village level MSS Trng. programme (1997)	3215	2920	90

C. BUDGET MADE AVAILABLE FOR IEC ACTIVITIES

Sl No.	Year	Budget
1.	1997-98	75.01 lakhs
2.	1998-99	90.86 lakhs
3.	1990-200	61.48 lakhs

D. REMARKS OF THE DIRECTOR, R.C.H.

Though IEC is the base for creating demand generation for Family Welfare and Maternity and Child Health Services, the inadequacy of funds has become a major barrier in the implementation of IEC strategy. On an average, Rs. 70 lakhs are being spent on IEC per year under FW & MCH for a population of more than 5 crores in the State. This is a very meagre amount. However, there are various thrust areas under FW & MCH which are not effectively covered.

With the introduction of Panchayathraj System in Karnataka, implementation of IEC at district level has become very difficult. It is observed that a major portion of amount earmarked for district levels activities remains unspent as the amount is either released very late or not released to District Health and Family Welfare Officer by Zilla Panchayats.

Many posts of health education personnel are remaining vacant at all levels. Many Primary Health Centres do not have sanctioned post of Block Health Educators and even sanctioned, posts are not filled. 255 posts are vacant for 782 sanctioned posts of Block Health Educators. With all these constraints, IEC activities have played a vital role in popularising FW & MCH programme in Karnataka.

Inference on the data presented above and on the remarks of the Director.

IEC activities are planned depending upon the budget made available for health education by the Central and State Governments. The budget allotted is too small compared to the need. With so many eligible couple living in 27066 villages spread over 1.92 lakh square kilometers it is impossible to reach them and create awareness and motivate them. In fact, the progress made under RCH care especially in promoting spacing methods is very low and so also increasing the age at marriage. Percentage achieved under film show and exhibition is only 43% and 37% respectively. This is not encouraging.

The progress achieved so far in brining down birth rate and increasing the couple protection rate (58.6%) cannot be attributed solely for these IEC activities. Most of the awareness about family limitation may be cumulative effect of all the formal and informal health education activities and public opinion and social pressure that were going on in the State over the years. The people in the State seems to have realised that small family norm is best for their well-being and women in particular are coming forward for permanent method even with one girl child. However, the present progress in couple protection rate is entirely due to permanent method, that too female sterilization. Therefore, efforts should be made to remove the unmet needs of nearly 11.5% of eligible couples and popularise and

motivate people to accept spacing methods to improve their health as well as reducing the infant and under 5 years childrens morbidity and mortality. This will also help to being down maternal mortality and morbidity. The male participation is also important in the community. Another crucial and important health promotional measure is increasing the age at marriage of girls. This is important in the long run. Both these measures are necessary to bring about sustainable behaviour of people for small family norm.

Further, progress in RCH is possible only by health promotional strategies of advocacy, social support and empowerment. Therefore, the State Health Education Bureau should gear up to the task in coming years,

Functions of H.E.B. II

The functioning of this section of Health Education Bureau is very important to reach the long term goals set by the Bureau. However, the functioning of this section is not very satisfactory. This Section consists of 5 State level units with technical and non-technical staff. These units are (1) Audio-visual Unit (2) Field Study and Demonstration Unit (3) School Health Unit (4) Exhibition unit and (5) Training Unit. Some units are not working because of posts sanctioned are vacant for a long time and sufficient grants are not made available for effective functioning. Each of these have a definite function to perform.

For example (1) The Audio-visual unit is concerned with (a) training different categories of health personnel in audio-visual education and preparation of A.V. aids (b) Designing, production and procurement of A.V. aids and other educational materials of use in the field (c) assisting in the evaluation of A.V. aids produced in the Bureau. This section is not functioning because most of the key posts are vacant for a long time.

(2) Functions of Field Study and Demonstration units are (a) To find out most suitable, and cost-effective methods and media of health education (b) planning, organising and implementing and demonstrating research-cum-action programmes (c) investigation of various health education issues that may arise from time to time and assist in solving them. Thus this unit is very essential for supporting health education activities. This unit also is not functioning because of the absence of the key staff for a very long time. The existing staff do carry out some in the field demonstration unit, but it is negligible and not based on scientifically planned studies.

Therefore, the staff for both these units should be found as early as possible and these units should be energized, Both these units are very important to plan and bring out scientifically based evidence for health promotional activities and

materials they produce and use and also to bring out relative cost effectiveness of several media they use.

(3)Exhibition unit which is very important for planning health exhibitions for the State. It is not functioning properly because of the absence of the key staff over a long time.

(4) Student School Health Education Unit and Training Units are however functioning. Their performance is given below.

SCHOOL HEALTH EDUCATION PROGRAMME

School health programme is a State plan scheme and started in the 3rd 5 year plan period. The objectives and goals were laid down as per recommendations of Smt. Renuka Ray Committee Report in 1965. The school health programme first covered 30 primary Health Centres in 1965 and extended gradually to cover 35 Primary Health Centres in 1969, 103 Primary Health Centres in 1973, additional 300 Primary Health Centres in 1980, 90 Primary Health Centres in 1985, 100 Primary Health Centres in 1985, 122 Primary Health Cnetres in 1987, 465 Primary Health Centres in 1998 and thus by 1989, 1245 Primary Health Centres, out of the present 1686.

Goals and objectives.

Goals: To enhance and Promote health education of school children in every possible manner to enable them to adopt measures to achieve and remain healthy and develop in them a self reliance and social responsibility and better quality of life not only as children of today, but also as adults of tomorrow.

Objectives

1. Promotion of positive health.
2. Prevention of diseases.
3. Early diagnosis, treatment and follow up of defects.
4. Awakening health consciousness in children.
5. Provision of healthful school environment.

Activities

To reach the above goals and objectives, the following activities were planned to be implemented.

1. Health appraisal of school children.
2. Remedial resources and following up.
3. Prevention of communicable diseases including vaccine preventable diseases.
4. Healthful school environment.
5. Nutritional services.
6. Mental Health and Dental Health and Eye Health.
7. Health Education.
8. Health Education of the handicapped Children.
9. Teachers training.
10. Proper maintenance and use of school health record.

Organisation for implementing the school health scheme

School health service is one of the basic responsibility of State Health services and it is incorporated in the functioning of primary health Centre throughout the State. Therefore, the entire State health organization from sub-centre at the grass root level to the head of the Health Education Section at the State level are responsible for implementing the scheme. The primary health centre staff plan and implement the school health programme in their areas, district health supervisery staff (District Nursing superviser) and give guidance and monitors the progress.

The District Health and Family Welfare Officer reports to the head of the Health Education and Training section of the State Health Education Bureau at the State level. The District Health Education Officer plans and implements the health education activity through the Block Level Health Educator. The Medical Officer of Health of the Primary Health Centre is responsible for medical examination and follow up of the health of the school children with the help and assistance of Health Workers under his/her control.

Performance.

	Activities	**Extent of Coverage**
1.	Health appraisal	Only medical examination is carried out.
2.	Remedial measures and follow up	Done very superficially
3.	Prevention of communicable diseases including vaccine preventable diseases	Only immunization services given to 1, 4, 7th standard children. No other communicable diseases is detected or treated.
4.	Nutritional services	No programme.
5.	Health Education	Not carried out systematically
6.	Teacher training	Carried out, but not sufficient.
7.	Maintenance of school health record	Not done systematically
8.	School environment, water supply and sanitation	Nothing is done

As shown above, the performance is patchy and all activities are not carried out except the medical examination and immunisation of 1, 4 7th standard children Teachers training is also not sufficient and the progress is not satisfactory. No attempt is made to take up any activity under school environment and sanitation in schools. The follow up service is very unsatisfactory. Only activity that is carried out under the school health service is medical examination and teachers training which is given below.

TABLE – 3

Showing performance is some activities of school health service during 1999-2000

	Activities	Percentage of target achieved 1999, 2000	
1.	Medical examination of school children	...	80%
2.	Immunisation		
	➢ 1st standard	...	83%
	➢ 7th standard	...	100%
	➢ 10th standard	...	73.54%
3.	Teachers training	...	69.55%
4.	Medical defective found	...	17.63%

As per the records furnished by the Health Education and Training (HET) of the State Health Education Bureau, only school medical examination, teachers training and immunization services are monitored at the State level. The performance of each district is scrutinised and progress noted. The district which lag behind are noted and remarks sent to the respective District Health and Family Welfare Officers. Though the physical targets achieved are above 80%, the quality of service appears to be very poor. During out visit to about 8 Primary Health Centres in 4 districts, we had a chance to look into the school health records and to discuss the matter with school head masters. Medical examination is done mostly by Health Assistants and not by the Medical Officers except in Kodagu District. There is no follow up services. The quality of training of teachers is not satisfactory according to most of the teachers. Teachers also feel that it is an additional job and many of them are burdened with other school regular curricular activities. Health education in schools is not carried out regularly and it is very unsatisfactory.

Recommendations

School health service is one of the most important health promotional activity. Though it is a regular activity of the Health Department and Medical Officer of Health of Primary Health Centre is responsible for a least medical examination of school children, it is not done properly.

Medical Officers of Health should be activated to take up school medical examinations seriously and the performance monitored by the District Health and Family Welfare Officers and the MOHs who are lagging behind should be reprimanded.

Health Education activity should be planned and every school in the Primary Health Centre area should be covered. The Health Supervisers at the PHC level must be made responsible and the District Nursing Superviser and the District Health Education Officers should monitor the programme and report to the District Health and Family Welfare Officers.

There is no attempt to improve school environment Water supply and toilet facilities should be provided to every school. This should be taken up as a priority. This involves substantial investment and efforts should be made to raise donations in the villages by giving equal contribution from the Government. This may be taken up a phased manner.

Teacher training should be intensified and quality of training improved. There should be at least one trained teacher in every school in the State by the end of 2002.

The furniture, flooring in most of the schools is very poor and should be improved.

Though this programme a combined responsibility of Health and Education Departments, the Education Deptt., is not evincing sufficient interest in the programme. District Health and Family Welfare Officers must start advocacy programme for District Education Officers and Zilla Panchayat President and the District Executive Officer. The Additional Director of Health and Family Welfare Services should meet his counter part at the State level and bring pressure on the District Education Officers. The District School Health Councils and State Health Councils should meet periodically and hold discussion on the performance of school health activities.

The government and Zilla Panchayats should be persuaded to invest in providing toilet facilities in all schools in the State.

The vacant posts in Field Study and Demonstration Unit, Audio-Visual Unit, Exhibition Unit should be filled up urgently and these units should be made functional and energised.

Question of brining all IEC activities under the Health Education Bureau should be closely examined because the health education work in there programmes should not suffer when it is most needed. The programme directors know when

they should launch health education campaign and where. It is his responsibility to achieve completion of the control programme. (Disease/Epidemic)

The routine health education programme covering all the areas of public health should be the responsibility of State Health Education Bureau and special health education campaign should be left to the respective programme Directors.

Recommendations on repositioning of Health Educators.

Ideally every PHC should have one Health Educator. Due to financial stringency this may not be possible for the next few years. There fore one Health Educator may be attached two PHC and stationed at taluka Health Office under the supervision guidnes and control of taluka Health Officer

All the BLHEs should be deputed to acquire DHE qualification at the rate of at least 50 every year.

At the District level one District Health Education Officer and one Deputy District Health Education Officer may be retained.

At the Taluka level there is need for one senior Health Educator to coordinate the work of PHC level Health Educators. This will strengthen the taluka level health organization and enables them to plan and carry out effectively IEC activities

The Health Task Force may suggest to the Govt. to allocate at least 5 to 10% of the health budget for health education purposes as approved by Central Health Council.

SECTION –IV

1. Grass Root Level Workers
2. Health supervisors
3. Health Educators
4. Interaction with other Health Related Departments
5. Interaction with Non-Government Organisations
6. Interaction with people

1. GRASS ROOT LEVEL WORKERS

Total of 50 workers from 4 Districts posted to 16 Primary Health Centers were interviewed and they were questioned about their knowledge and practice of health education and observed their attitude towards the subject of health education.

Competency

Most of them are aware of their responsibility (80%) and felt that health education is one of their most important and frequently undertaken job. most of them (85%) showed strong positive attitude towards the job. in fact many expressed, they are able to do their job because of their health knowledge and their ability to talk to them and convince them about the health benefits of their action. About 75% of them know various methods of health education and social mobilization techniques. However , they are not making any efforts to get the cooperation of the Village Health Committee and local people. The people's participation in conducting health programme at the grass root level is not much appreciated by the field workers and their efforts to involve them is almost absent. Participation by members of the Mother Swasthya Sangha (MSS) is however appreciated by all the workers. Most of the m are expressed they must have frequent meeting involving mother-in-laws and daughter-in-laws and other elders, where they can discuss common health problems and remove some doubts and misunderstanding, superstition about child birth and child care.

Interaction with other Sectors

Grass root level workers get the maximum cooperation and help from the Community Development Departments through Anganwadi workers. Inter-sectoral cooperation from other sectors is not appreciable except Revenue Department from whom they get pregnancy allowance sanctioned to their clients.

Table-4

Grass root level workers, their level of knowledge and attitude on various aspects of Health Promotion and Education Interviewed

Sl No.	Percentage	High	Moderate	Low	Total Number Responded
1.	Awareness of job responsibility	80	16	4	50
2.	Knowledge	80	12	4	50
3.	Attitude	75	14	6	50
4.	Need assessment capacity	76	14	10	50
5.	Knowledge about health Education method	80	12	8	50
6.	Social mobilisation tactics	60	30	10	50
7.	Knowledge about the State of people and N.G.O participation	70	10	20	50
8.	Need for Inter-sectoral Coordination	80	16	4	50
9.	Methods to be used in Health promotion				
	Advocacy	20	40	40	50
	Social support	10	30	60	50
	Empowerment	10	20	70	50

Inference and recommendations

The knowledge, attitude and practice of grass root level workers with regard to health education as one of their prime duties and its importance in implementing any health programme is satisfactory. However, they are not in a position to appreciate and involve the local people in their planning or implementing health programme in the villages. Though they understands the need and advantage of involving local leaders in conducting health programmes, they do not have the skill to do so. Therefore, there is a great need for training the grass root level workers in development of skill as to how to involve the local people in the health programme. People participation in health activities in health activities under the primary health care strategy is one of the main function of the Primary Health Centre as recommended by the Alma Ata Declaration. It has also been realized throughout the world both in developed and developing countries that people's participation is sine qua non for the success of any health programme, and it (people's participation) should assumes greater significance in health promotion strategy.

Mother Swasthya Sangha (M.S.S) activities were appreciated by all. This progrmme should be strengthened and frequently arranged, but such programmes will have to be monitored and supervised by the Health supervisors. These meetings and contacts are conducted only once in a way or whenever the money for it is released. This should not be the case. The programme should be a routine duty of health workers. Health Workers male and female in every sub-centre should plan their contact meeting per month in every village.

IEC activities in each village should be planned and conducted by making use of local school children, teachers, retired people and other public spirited social workers. Both male and female people should be encouraged to participate. Organised community activities have better impact in creating awareness.

2. Health Supervisers

A total of 28 health superviser staff from 4 districts were interviewed. As shown in table 5 all of them are aware of their over all responsibilities and they know that health education is one of their duties. Conversation with them revealed that they have good knowledge about supervision and guidance. They undertake frequent tours of their area and help the grass root, health workers is difficult cases of refusals of advice and resistant cases towards family limitation. Their knowledge of supervision and guidance is only with reference to normal, routine personal health education to the individuals. However, they also participate in group education like M.S.S activities and jathas and video shows and baby shows. In

many places, Health Supervisors are resource personal for local NGO for their education campaign. However they need training in health promotion strategies.

Problems of Health Supervisors

Many of them are quite senior people with 15 to 20 years of service. They do not have promotional opportunities, because only few of them get a district Supervisory position. This aspect has led them to feel frustrated and have become less enthusiastic in their job. This should be halted by appropriate remedy. Most of the health work at the grass root level is carried out by the grass root level workers and their supervisors. The department is illoffered to neglect their services, especially in the field of health education. In fact, in many PHCs, it is the senior health supervisor who manages the PHC activities because the Medical Officer of Health is either absent or attends only to clinical work.

TABLE – 5

Health Supervisors, their level of knowledge ,attitude on various aspects of health promotion.

Sl No.	Percentage	High	Moderate	Low	Total Number Responded
1.	Awareness of job responsibility	80	15	5	28
2.	Knowledge	70	20	2	28
3.	Attitude	80	16	4	28
4.	Knowledge and ability in need assessment	80	10	10	28
5.	Ability to supervise and guide	78	12	10	28
6.	Social mobilisation capacity	75	15	10	28
7.	Knowledge about the need and role of peoples participation	80	18	2	28
8.	Inter-sectoral Coordination	65	15	20	28
9.	Knowledge on Health promotional strategies				
	Advocacy	20	60	20	28
	Social support	18	70	12	28
	Empowerment	15	60	25	28

Inference

Though Health Supervisors are important at PHCs level, for health education programmes , there seem to be complacency in their attitude and practice. This may be due to the (1) presence of Block Level Health Educator, who is responsible for implementing the organized health education or IEC activities at the PHC level and (2) also the Medical Officers of Health are not taking any interest in administrative affairs of the PHC and leave everything to the Health Supervisors. Health Education as an activity at PHC level is suffering from these two constraints. Both these Constraints must be attended to by Medical Officers. They must be made to take more interest in administration and management of health programmes including health education at the PHC level.

There is need for proper supervision and monitoring of PHC performance from the District Health Officers

Recommendations

The Health Supervisors must be made responsible for all health education activities at the PHC level. The administration should activate these people more particularly the Medical Officer of health must be made to take interest in administration and management. This is possible by frequents visit of the District Health and Family Welfare Officers to the PHCs and arranging seminars and symposium at District level for all Medical Officers of health.

Block level Health Educators, District Health Education Officers and Deputy District Health Education Officers

14 Block level Health Educators working at the Primary Health Centres, 4 districts Health Education Officers and 4 Deputy District Health Education Officers working at District level were interviewed and participated in focus group discussions.

Competency

Health Educator is a facilitator for Health Promotion at grass root level. He has to plan and organize Health promotion programmes and implement them through the grass root level workers.

As shown in table 6 most of them aware of their job responsibilities and know the job well. They have the right kind of attitude and appeared enthusiastic in their

job. They have sufficient skill to develop education programmes. However, they are not making use of their skill in social mobilisation work and involving people in health education activities. For Example, 90% of them have sufficient knowledge about the need for inter-sectoral co-ordination and N.G.O involvement, but only 30% of them are making efforts. When asked why it was so, many of them expressed that they are neglected lot. There contribution is not recognized by superior officers. Only 50% of them have right kind of communication skill and 40% of them are capable of talking to people on any subject. Their knowledge about advocacy is satisfactory, but their ability to practice is doubtful. They do not have sufficient knowledge about social support and empowerment. Except 5 District Health Education Officers, all others need intensive training in the principles and strategies of health promotion.

Recommendations

Long Term

The Health Educator at the taluk and primary Health Centre Level and the district Health Education Officers and the Deputy District Health Education Officers at the District level are the key persons for planning and implementing IEC activities. They should have sufficient knowledge about the community and community leaders and should be enthusiastic and committed for the task of spreading scientific knowledge to people and involve them in health programme. In fact part of the reason for tardy progress of health programmes is attributable to non-involvement and half hearted participation of people. This is the case in all health programmes. It may be improper Malaria Education, poor Tuberculosis control low couple protection rate etc. Therefore, training and retraining of the health educators in social mobilisation methods and in various modern communication technology is urgently required. Most of them take their job very casually and do things very slowly. This may be due to lack of administrative pressure from districts, which may be strengthen.

Short term

Immediately, there is a great need to arrange training programme for all health Educators on health Promotion. A programme of reorientation for District Health Education Officers and Deputy District health Education Officers and those possessing DHE qualification may be organized at the state level in two or three batches. The course may be of one week duration.

For those BLHEs without DHE qualification, a two week training programme may be organized at the Divisional level so that all the Health Educators are trained and

equipped with skills to plan and implement IEC activities under health promotion strategies as recommended by the Ottawa Conference on Health promotion. **More specifically they need training in group dynamics, motivation, communication, interpersonal relationship, intersectoral coordination and social mobilization. They should also be trained in modern electronic media and utilization of computers.**

TABLE - 6

Block Level Health Educators. District Health Education Officers and the Deputy District Health Education Officers their level of knowledge and attitude and ability

Sl. No.		Percentages		
		High	Medium	Low
1.	Awareness of job responsibility	80	15	5
2.	Knowledge	90	7	3
3.	Attitude	95	4	1
4.	skill of collecting and analyzing health need assessment	65	20	15
5.	Knowledge of health education methods	80	10	10
6.	Social mobilisation tactics	70	20	10
7.	Knowledge about the local leaders , religious groups and need to involve them in health education activities	60	25	15
8.	Need for inter-sectoral co-operation and NGO involvement			
	Knowledge	90	5	5
	Practice	30	30	40
9.	Communication ability	50	25	40
10.	Ability to write, press release and talk to lay people	40	40	20
11.	Knowledge about health promotional activities	40	40	20
12.	Knowledge about advocacy	40	45	15
	Practice of advocacy	20	20	60
13.	Knowledge about social support practice of social support	60	30	10
		20	30	50
14.	Knowledge about empowerment practice of empowerment measures	40	30	30
		20	40	40

MEDICAL OFFICERS OF HEALTH

Twelve Medical officers of Health from 4 Districts participated in the discussions. Opinion and their response to various issues is given below. Many of them know the importance of health education and the need for extensive health education efforts. They also know that health education is one of their duties, but they did not show any enthusiasm and interest in health education activities. Those who do not have much clinical practice do well in all health programme including health education and those having good clinical work say that they do not have enough time to do so much of non clinical work including health education. in fact, medical officers who have good clinical practice take help of health workers to assist him. Doing clinical work is good for the people, because many patient need not go for distant places for primary medical care. **Therefore, the clinical practice should not be disturbed. the principle of integrating clinical practice with non clinical work like administrating and management of health programme has been a failure. Now Taluk Health Offices have been established and Taluka Health Officers must be made Administrator of Health service in the Taluk and all the Health Workers including Medical Officers of PHCs should come under his administrative control.**

THE MEDICAL OFFICERS WERE QUESTIONED AND THEIR OPINION WAS COLLECTED. THE RESULTS OF THE ANALYSIS IS AS FOLLOWS

Sl No.	AREAS EXAMINED	REMARKS
1.	THE NEED FOR HEALTH PROMOTION.	ALL AGREED VERY STRONGLY.
2.	METHODS OF PLANNING HEALTH PROMOTIONAL ACTIVITIES	ALL AGREED, BUT THEY DO NOT WANT TO TAKE PART, IN PLANNING PROGRAMMES
3.	IMPORTANCE OF SOCIAL MOBILISATION	MANY DO NOT HAVE ANY IDEA OF SOCIAL MOBILISATION STRATEGY
4.	NEED FOR INVOLVING PEOPLE IN HEALTH PROGRAMMES	50% AGREED, BUT ANOTHER 50% SAID PEOPLE DO NOT COOPERATE.
5.	NEED FOR FURTHER TRAINING OF HEALTH STAFF	ALL AGREED THAT HEALTH WORKERS SHOULD BE TRAINED AND NOT THEMSELVES.
6.	QUALIFICATION REQUIRED FOR HEALTH EDUCATORS	ALL AGREED THAT THEY SHOULD HAVE DHE QUALIFICATION
7.	ADDITIONAL TRAINING FOR MEDICAL OFFICERS OF HEALTH	MAY BE USE FULL. ONCE IN 3 YEARS FOR UPDATING THE RECENT ADVANCES
8.	NEED FOR ORIENTATION OF SYLLABUS OF COMMUNITY MEDICINE IN MBBS COURSE	ALL AGREED THAT THEY MUST BE EXPOSED MORE AND MORE TO THE COMMUNITY. AND ALL NATIONAL HEALTH PROGRAMMES SHOULD BE DEMONSTRATED TO THEM IN MORE DETAIL.
9.	NEED FOR CHANGE IN THE ATTITUDE OF POLICY-MAKERS TOWARDS PUBLIC HEALTH	THEY AGREED THAT PUBLIC HEALTH WORK IS NOT APPRECIATED BY MANY DOCTORS IT IS RARELY THAT GOOD HEALTH WORKER (DOCTOR) IS APPRECIATED, WHERE AS GOOD CLINICIAN IS APPRECIATED BY ADMINISTRATORS AND POLITICAL LEADERS, ALIKE

OPINIONS OF PUBLIC HEALTH EXPERTS ON SOME ISSUES OF HEALTH PROMOTION

Health promotion is a part and parcel of public health. In fact the goal of public health is to create the environment conducive, and mould the behaviour of all people favorable to positive health. Health promotion comes even before the primary level of prevention. It is also called primordial prevention. Therefore Health promotion is not something different from the main stream of public Health philosophy and public health Actions

Opinion of public Health experts was sought about some aspect of health promotion. 98 people were approached in and out of the state and 48 people responded. Their opinion is given below. Opinion expressed by experts is overwhelmingly in favour of application of principles of Health Promotion in the Public Health Action Programmes. Most of them also express that public health in recent years in being neglected by policy makers and due status is not given to the Public Health & Public Health experts.

This will have to be over come by appropriate advocacy programme for top-level policy makers.

OPINION OF PUBLIC HEALTH EXPERTS

SL No.	STATEMENTS RELATED TO	AGREED OR NOT (PERCENTAGE) STRONGLY AGREED	AGREED	DISAGREED
1.	THE NEED FOR HEALTH PROMOTIONAL STRATEGIES AND THE RATIONALE AND POSSIBILITIES OF IMPLEMENTING IN DEVELOPING COUNTRIES	20	80	-NIL-
2.	METHODS OF PLANNING AND IMPLEMENTATION	10	90	-NIL-
3.	IMPORTANCE OF SOCIAL MOBILIZATION	5	90	5
4.	NEED FOR INVOLVING PEOPLE IN HEALTH PROMOTION PROGRAMME	3	90	7
5.	NEED FOR TRAINING FOR MEDICAL OFFICERS OF HEALTH, & DISTRICT HEALTH AND FAMILY WELFARE OFFICERS ON HEALTH PROMOTION	10	90	-NIL-
6.	DESIRABILITY OF DHE QUALIFICATION FOR HEALTH EDUCATOR AND DPH QUALIFICATION FOR HEALTH &FAMILY WELFARE OFFICERS	5	90	5
7.	NEED FOR STRENGTHENING SYLLABUS IN COMMUNITY MEDICINE FOR MBBS AND DPH	3	90	7
8.	NEED FOR CHANGE IN THE ATTITUDE OF POLICY MAKERS, POLITICIANS TOWARDS PUBLIC HEALTH	3	95	2

OPINION ON SOME OF THE IMPORTANT STATEMENTS ON PUBLIC HEALTH POLICY

Sl No.	STATEMENTS	PERCENTAGES	
		AGREED	DISAGREED
1.	THE CONCEPT, PRACTICE AND IMPORTANCE GIVEN FOR PUBLIC HEALTH BY HIGHEST DECISION MAKING PEOPLE ARE FOR IMPLEMENTATION OF HEALTH PROMOTIONAL STRATEGIES.	100%	-NIL-
2.	ONE OF THE MAJOR BARRIERS FOR IMPLEMENTING OF THE HEALTH PROMOTIONAL STRATEGIES IS THE LACK OF PROPERLY TRAINED PUBLIC HEALTH EXPERTS AT THE HIGHEST DECISION MAKING LEVEL AND AT THE MIDDLE PLANNING AND IMPLEMENTING LEVEL	98%	2%
3.	PUBLIC HEALTH RESERCH IS NOT MAKING THE NECESSARY CONTRIBUTION TO PUBLIC POLICY, BECAUSE OF ITS TENDANCY TO WANT TO BE SEEN AS EXCELLENT RATHER THAN ANY RELEVANCE TO THE NEEDS OF PUBLIC POLICY	70%	30%
4.	MOST PUBLIC HEALTH PROFESSIONAL AND CLINICAL PROFESSIONALS WORKING IN PUBLIC HEALTH POSITIONS IN THE COUNTRYHAVE LITTLE TRAINING IN WIDER ASPECTS OF HEALTH. THEIR EXPOSURE TO RELEVANT SOCIAL SCIENCES AND HAVE HAD LITTLE OPPORTUNITY TO LEARN FROM ROLE MODEL HOW TO ADDRESS THE SOCIAL, ECONOMIC AND POLITICAL FORCES AFFECTING HEALTH	60%	40%
5.	POLICY MAKERS IN PUBLIC HEALTH AND HEALTH PROFESSIONAL SHOULD MEET REGULARLY TO REVIEW THE HEALTH PROBLEMS AND RESERCH EVIDENCE AVAILABLE FOR THEIR DECISION MAKING	100%	-NIL-
6.	IN ADDITION, THE PUBLIC HEALTH SPECIALIST NEEDS SKILLS IN COMMUNICATION, PUBLIC POLICY ANALYSIS AND DEVELOPMENT	90%	10%
7.	SOCIAL PROGRAMMES (THIS INCLUDING HEALTH) ARE OPERATING UNDER EVER TIGHTER RESOURCE CONSTRAINTS. THEREFORE, THE CONTRIBUTION OF GOOD HEALTH TO SOCIO-ECONOMIC DEVELOPMENT MUST BE CONVINCINGLY DEMONSTRATED IF ADEQUATE AND SUSTAINABLE RESOURCES ARE TO FLOW TO THE HEALTH SECTOR	100%	-NIL-
8.	RESOURCE ALLOCATION FOR PUBLIC HEALTH MUST BE MORE EQUITABLE CONSISTENT WITH ITS CONTRIBUTION TO SOCIAL DEVELOPMENT AND NEW RESOURCES SHOULD BE MOBILIZED	100%	-NIL-
9.	THE GOVERNMENT SHOULD FIND WAYS AND MEANS TO ENHANCE THE STATUS AND IMAGE OF PUBLIC HEALTH CARE PROFESSIONALS CONSISTENT WITH THEIR CRUCIAL ROLE IN HEALTH OF THE NATION.	100%	-NIL-

4. Interaction with other health related departments

Findings

Intersectoral coordination of all development departments of the government is important for speedier and effective implementation of health promotional programme. In this connection, the representatives of the following departments were contacted and information collected by using structured questionnaire. They are Education, public Health Engineering, Information and broadcasting, Agriculture and Horticulture departments. **Most of them agreed that there is need for cooperation and coordination between health Departments. and their departments but expect that their departments but except that the health department to take inactive in the matter because health is the business and concern of health sector. Many of them are not happy about the attitude of doctors towards them.**

Recommendations

First of all there is need to educate other departments to impress on them, that health of the people is their concern also and if there is cooperation and coordination, the health promotional programme can be implemented smoothly and quickly. Moreover, the proper and successful implementation of health programmes would also help other non health related programme substainlly, because people take more and keen interest if the programme is health related. Therefore, there is need for organizing advocacy programme for managers and policy makers of other development departments at the State level, they should be identified and educated. A programme for people can be effectively and efficiently implemented, if all departments extends support and participate for example, the success of family Welfare programme to some extent is due to the extensive intersectoral coordination and cooperation. The benefits that flow from intersectoral coordination is much more than the benefits that accrue when departments work separately.

This is the fruit of interaction and this does not cost any thing more 'instead' strengthens interpersonal bonds and Interdepartmental bonds and help cohesion and purpose in government institutions. This is very important because people are loosing confidence in government run programme.

5. Interaction with Non-Governmental Organisations

Eight non-government organization in 4 districts implementing some health education activities were contacted. All of them are very much enthusiastic to do

health work and help people to improve their health. But most of them are dependent on government for funds and projects. The projects managed by the NGOs are better organized and people are satisfied by the services. Some of them engage full time staff. These workers seem to be more serious about their responsibility and duty and they have better rapport with the local people performance of NGO seems to better than government organization but the budget of NGO seems to be better than government organization.

In the long run it may be better to involve more and more NGOs and try to encourage them. Unless socially spirited people come forward to manage non-government organization and if they are allowed to work only with full time employees and work like any other profit oriented organizations, they would become very soon as government run institutions. Therefore carefull verification of non-government organization and the staff composition and the background of people who run such organisationis required before entrusting any health related projects to them.

6. Interaction with the people

It was possible to meet some people in village in all the 8 primary Health Centres of 4 Districts Both men and women in their homes and in public places were interacted to understand whether they know the health education and other health programmes and whether they are getting adequate information about health.

Findings

Most of the respondents showed indifference to our questions on Probing further, they reveled that the health worker come and talk to them on health matters sometimes on family planning and antenatal care. Mothers expressed that ANMs are advising them on diet and child care. They are not aware of any other Health Education Campaign on other Health activities Except Aids/HIVs.

Many village are not satisfied by the services they receive when they go for the Primary Health Centre for Treatment, except immunization services.

Nevertheless, it is surprising to know that many of the villagers have understood the rationale of small family norm and they do not have much gender discrimination and coming to sterilization camps even with one girl child. But many are not male sterilization.

Most people want water supply at their doors through taps and some of them are also willing to bear the expenditure on it, but they do not know why they want

piped water supply. They do not know the importance of sanitation and are not interest to have toilet facilities in their homes.

Recommendations

Therefore, there is need to launch health education programme systematically and continuously by the government. The television media and radio should be used more frequently to reach large number of needy people. The messages should be transmitted instead of scholarly talks through media. Prime time should be chosen for telecasting messages and slogans. These programmes should be supplemented by health workers in the field by way of clarification etc.

SECTION-V

1. **Vision and Strategy Statement**
2. **Summary of the findings discussion and recommendations.**

1. A vision strategy statement for improving the health status of Karnataka State in 21st Century

India including Karnataka State is facing a triple burden of diseases and disability even after 50 years of development after attaining political independence. The first burden is that many preventable disease and disability still persist as public health problems. This is due to party, to administrative and technical problems in the control of infectious and nutritional diseases and party due to failure in public health policy.

In addition, due to demographic transition and increase in expectation of life, people are surviving longer. Unfortunately they survive to suffer from costly diagnostic facilities, costly drugs and longer hospital stay. Relatively, more health budget is being spent on elderly people than young and working people. This is the 2nd burden.

The third burden is the emergence of new diseases like HIV/AIDS, Alcoholism, and Drug abuse.

These challenges together with higher infant mortality rate (70/1000), higher proportion, low birth weight babies (30%) and higher mortality among under 5 children all pose a formidable disease burden to the state

In the face of these challenges, the health care system in the state is not that efficient as revealed by slowing down of decline of IMR and under 5 year mortality (1999-2000). In recent years incidence of malaria, tuberculosis and HIV/AIDS have also shown increasing tendency.

Therefore, there is a clear indication that the present and past public health policies and strategies are not sufficient to lesson the burden of disease and disability in karnataka. This situation has lead the state to spend more and more for curative services and get less and less in terms of health gain to the population. The experiences of western countries from 1801 to 1971 has shown a similar trend.

Ottawa charter after considering all the above factors, has suggested to all countries to apply the principles of health Promotion in their health policy. The

Karnataka State would do well to implement these strategies to achieve the maximum benefits in terms of improved health. These strategies would help the people and government to reach the determinants of illhealth and destroy the roots. Even though this is a long, arduous and expensive task, it is the only way left for reducing the burden of disease and disability, and to promote the health of the state.

The 5 strategies suggested by the Character are:

1. Build healthy public policy
2. Create supportive environment
3. Strengthen community action
4. Develop personal skills
5. Reorient health services

Major areas of concern that should be adequately addressed are:

- ❖ Development of human resource
- ❖ Sustained action to build supportive environment for all people
- ❖ Fostering intersectoral action for health
- ❖ Forging partnership between non-government organisation and government health sector.

With the application of principles of health promotion and hopefully improved, health administration, the state may hope to improve health status of people of Karnataka, sufficient enough to live a healthy, useful and procedure lives at least by 2015 in 21st century.

2. Summary of the Findings, Discussion and Recommendations.

The study reveals that the Karnataka state Health Department has required organizational infrastructure, manpower and skill to launch Health promotional activities in the direction as suggested by the world health Organization's 9th General programme of work. However, some minor deficiencies and week linkages have been found in the study and they are discussed below and remedial measures suggested in the way of recommendations.

A. ORGANIZATIONAL STRUCTURE

The existing organizational structure in the state to take up the health promotional activities at the State, District, Taluka and primary Health care center level is adequate and no additions or modifications are required. The name of the state Health Education Bureau. All the Health Education staff may be brought under one division.

B. MANPOWER

State level

Some posts of Technical Officers of the Health education Bureau at the state level are vacant for a long time. This has led to the disfunctioning of these units and State health Education Bureau is very much handicapped without these Units. For Example, the Audio visual Unit is essential for pre–testing all IEC materials before they are produced in large numbers to be cost effective. Likewise the field study and demonstration Unit is essential because the health promotional activities are field tested for their applicability to the population and the cost effectiveness is determined before they are applied to a larger area.

Therefore the vacant posts in Audio-visual, field demonstration and Exhibition units may be filled up urgently.

District level

At the district level, no addition is required. The posts of the District Health Education officer and one Deputy District Health Education officer may be continued.

Both of them should have DHE qualification (the state has sufficient number of DHE qualified Health Educators). Their designation may be changed as District Health promotion and Education Officer and Deputy District Health Promotion and Education Officer.

Taluka Level

At Taluka level, there is no Health educator post are sanctioned at present. Therefore, one Health Educator post may be sanctioned for every taluka. The State has sufficient number of health educator for 175 talukas these post must be filled with D.H.E qualified Health Educators.

Primary Health Centre Level

The State has 1685 Primary Health Centres (this may go up also) and there are 782 Health Educators. Therefore, there is shortage of nearly 900 posts. It is very necessary that each Primary Health Centre should have one Health Educator and therefore additional posts may be created in a phased manner at the rate of 200 per year for the next 5 years.

C. TRAINING AND PROFESSIONAL EDUCATION

Training

The Study reveals that the Health Educators and Medical Officers need training in the health promotional aspect. Short term training courses may be arranged for District Health Education Officers, Deputy District Health Education Officers and the Medical Officers of health of all Primary Health Centres at the State level and at Divisional level. The training may be of one week duration.

The Health Educators, without DHE qualification may be sent for acquiring DHE qualification at Gandhigram in a phased manner.

Professional Education

The Medical Offices of Health of Primary Health Centre or Health Administrators at District and State level should have right kind of attitude and interest in health promotion, because they are the kingpins in health care delivery system. Therefore, their attitude and interest in health promotional activities are important and essentional.

Since the medical students are molded in the philosophy of medical and health practice and service at graduate level and it is here they form attitude and learn and develop skills, for right kind of attitude and practices. The syllabus in Community Medicine in MBBS and DPH and MD courses must be adjusted to include Health Promotional aspect of health care in a substantial way. The Community Medicine Department must have infrastructure to demonstrate the operational aspect of Health Promotional activities. The Rajeev Gandhi University of Health Sciences may be requested at issue guidelines and modify the syllabus in Community Medicine for both at undergraduate, diploma and degree courses.

FUNCTIONS

IEC activities

Information, Education and Communication activities are very important and essential for creating awareness of health and its importance in the minds of people. This is the 1st essential step in any health education programme to enable people to take control of determinants of illhealth in the community. At the present moment, there are no sufficient routine IEC activities in the State except centrally funded programmes. The State health sector should plan and carryout Health Education Programmes as a routine function of the Department and sufficient resources sould be earmarked for this in the annual health budget. Sponsored programmes are also very few and they will not reach the people and their impact is negligible.

School Health Programmes

This programme is very important in inculcating the health knowledge, moulding childrens health attitude and develop right kind of healthy life style favorable for healthy living. A comprehensive health programme which is already in existence should be implemented in all schools in the State. Therefore, the Government may be requested to issue orders to activate interdepartmental committee and implement comprehensive school health programme. This programme should include (1) health appraisal and follow up including medical examination (2) teachers training (3) providing good, clean and well ventilated class rooms (4) safe drinking water and toilet facilities to all schools and colleges in the state.

Further a comprehensive health education curriculum may be framed and taught covering all aspects of health promotion in a graded manner to the 1st Standard to XII Standard students as is being done in Europe, Australia and USA. The curriculum should include environment, air pollution, green house gases, which are causes of illhealth. Healthy life style, population elements, family welfare and sex education HIV/AIDS etc. Health promotional measures required to be cultivated and practiced by the individual, family and community. Their social responsibility towards the health of others is very essential, for health promotion of the population.

The Subject of health promotion may be made a compulsory curricular subject in schools and appropriate educational material may be produced by State Health Education Bureau in collaboration with Health, Health Education and Educational Experts.

D. ETHICS, ADVOCACY, HEALTH RESEARCH AND PARTNERSHIP FOR HEALTH PROMOTION.

a. Ethics

Bioethics cannot be limited to medical practice and organ transplant. Bioethics is, in broader sense, includes all interventions upon human being whether in a group setting or individual. Health Promotion and Health Education are to produce a undoubtedly a type of intervention, to produce a modified life style, attitudes, and desires, wishes and way of life. Health promotion also covers inequity and injustice meted out to some section of society. In fact the rationale of application of health promotional measures is to uphold the dignity of human being, affirmation of human right and the freedom to empower himself to protect and promote health. So ethically also the health promotional principles are sound and the human right demands the application of these measures in civil society.

b. Advocacy:

For successful implementation of health promotional policies and activities, the health sector should develop strategies for Advocacy at various levels. It should be armed with solid evidence that health promotion works and is worthwile. The health department should have a strong support and useful partnership with industry and other non-government organizations.

Advocacy is required at all levels of governance. At the top level to policy makes, legislature and decision makers (specially resource allocators). Health administrators at the top level must be able to take strong leadership and plead with policy makers and exert pressure on them to change the directions of policy wherever it is not favourable for health promotion. For this to succeed, the health administrators should have solid and convincing evidence.

c. Health Research and Partnership

How and where convincing evidence is available? The scientific evidence can come only by health research. The State has vast potential for collaborative research in health field. There are 23 medical colleges with well equipped fully staffed, community medicine departments. The Government should foster partnership between Medical Colleges and the District Health Administrators for producing scientific evidence about the benefits of health, Promotional activities. Collaborative action research is chapter and more usefull because it gives feed back to the health programme manager to change the directions it required. This

is a highly potential area to develop and the Government can insist upon this while handing over 3 PHCs to the Medical Colleges as contemplated recently.

d. Funds

The funds for IEC activities, Advocacy programmes and social mobilisation programmes should be granted by the Government. It should be remembered that money spent on health promotion activities can bring 10 times more dividend than the money spent on drugs and purchase of sophisticated equipment. The Government should proceed in the direction of allocating more and more taxfunds for attacking root causes of diseases than treating diseases for cosmetic purposes.

The Central Health Council has already given guidelines to allot 5 to 10% of health budget for health promotion. This should exclude the investment on water supply and sanitation.

E. Intersectoral coordination

It is very clear and apparent from the literature and a decade of experience that health promotional areas overlap between many developmental departments. And the health promotion is possible only by developmental approach. Moreover, health promotion is essentially a social and political action and therefore, the health promotion goes beyond health sector and embraces all other developmental sector of Government. Therefore, intersectoral cooperation and coordination between departments becomes very necessary and crucial for successfull for implementation of health promotional activities. Many case studies and opinion of experts show that comprehensive multi-disciplinary health promotional programme yield better results than programmes by single sector.

The study reveals that there is no strong linkage between health sector and other development sectors both at the top and at the bottom levels. Therefore, modalities should be found out and experimented to secure firm coordination and cooperation amongst all developmental departments at the Ministerial, Secretary, Directors level at the District level and at the grass root level. Health promotional committee may be formed with the State Health Council with the Chief Secretary as the Chairman to oversee the policy directions, and matters of intersectoral cooperation between various sectors. Developmental sectors which are very important and whose activities comprises many health promotional components are the following:

- Education Department.
- Information and Broadcasting Department.
- Community Development Department.
- Agriculture Department.
- Department of Industry.
- Social Welfare Department and
- Public Health Engineering Department.

1. Education Department.

The study reveals that there is no strong linkage between Health and Education Departments in the State. A close liaison is very much needed between these two Departments because one of the most important health promotional programme in the long run is the School Health Programme (SHP0. For successful implementation of School Health Programm very close collaboration is essential. Already existing committees at state & District levels may be given sufficient responsibility & powers and resources.

2. Information & Broadcasting Department

This sector is very much relevant to day than ever before. Because of the explosion of information on health promotion and multitude of media telecasting such information. Many TV Stations in their enthusiasm to make T.V. shows attractive especially to the youths include scenes and actions that actually convey unhealthy life styles. **Therefore, there must be a Watchdog Committee to watch out such shows and bring it to the notice of controlling authority in the State. Such a Committee should include public people also.**

For purposes of telecasting health promotional activities by the governmental media, a plan of telecasts has to be prepared by the Information and Broadcasting Department and the health experts either from the Department of Health or from non-government organizations doing health promotion work to be consulted before **telecasting.**

Health Promotion and Education Bureau should prepare their own TV scripts and request the Information and Broadcasting Department to telecast periodically. Details may be worked out jointly by the two Departments. The Health Department should gather public opinions about the television shows that have health implications and bring the telecasts that gives mis information, wrong

information if any to the notice of the information and broadcasting department. Health Department through its health promotion and education wing should identify the health promotional elements in the programmes of these sectors and discuss with the respective authorities.

Similarly, the directions by the Government may be issued to all development oriented Departments to have a close liaison with the Health Sector.

3. Collaboration with non-government organisation

Health promotional activities are carried out mostly at the level of people, in the families, community, villages and slums. Proper understanding and cooperation of local non-government organizations are very useful and essential. At present there is no formal collaboration with the Non-Government Organizations. The Government may issue directions to the health sector to establish firm and sustainable relationship with local non-government organizations for implementation of health promotional activities. These organizations are very essential for social mobilisation, people's contact and people's participation in the programme.

SUMMARY OF RECOMMENDATIONS WITH REASONS AND EXPLANATIONS

Recommendation – 1

It is recommended to change the name of the Health Education Bureau as "Health Promotion and Education Bureau".

Reason:

First of all to conform with the recent advances in the international Health forum and secondly to add additional importance of health promotional efforts of public health. Because the health promotion incorporates other two fields of action in addition to health education. They are social support and empowerment of people for better health. Therefore, the organization that deals with health promotion should have the appropriate name as "Health Promotion and Education Bureau".

Action:

Ministry of Health and Family Welfare can issue an executive order to this effect.

Recommendation – 2

The existing two divisions of Health Education Bureau should be merged and all the health education staff at the Primary Health Centre, District level and at the State level should be brought under the newly named division of "Health Promotion and Education Bureau." This division should be headed by an Additional Director of Health and Family Welfare Services, who will work directly under the Director of Health and Family Welfare Services. However, the District Health Education Officer and Health Educators at Primary Health Centre will work under the control of District Health and Family Welfare Officer, Taluka Health Officers and Medical Officer of Health of Primary Health Centres.

Reason:

Health promotion and education activities need special efforts and attention of the health department. Health promotional strategies and activities will have to be planned, executed and monitored at the State level, District level, Taluka level and Primary Health Centre levels. Unless there are designated personnel at various levels, the programmes cannot be effectively implemented. Secondly, the health promotion and education is becoming a specialised field in view of advances in communication and multi media. Therefore, communication specialists and well trained and skilled specialists are required to understand and interpret various behaviour changes taken place in the community as a result of health promotion and education activities. Further, if all specially trained and qualified staff are working under one direction and control, they would perform better and will be more efficient and more productive because of their combined talents and expertise.

Action:

Ministry of Health and Family Welfare can issue an executive order merging the two divisions of Health Education Bureau into one division of "Health Promotion and Education Bureau".

Recommendation – 3

Every newly created Taluka Health Office should have atleast one qualified Health Educator. His designation should be Taluka Health Promotion and Education Officer. He has to work under the control of Taluka Health Officer and under the technical control of District Health Promotion and Education Officer. He is responsible for planning, implementation and monitoring of all health promotional activities with the help of Health Educators of PHC and grass root level workers and their supervisors at the Primary Health Centre.

Reason:

In the context of supervision and guidance of health promotion and education activities, the existing District Health Education Officer is not efficient because, of the vastness of the district and very large population to be served. Therefore, a supervisory and guidance staff at Taluka level will be good and can be more effective because he can contact the field staff

more frequently and the area he has to cover is reduced markedly. He can guide and supervise all the activities in all the PHCs of the Taluka and report to the District Health Education Officer (See also page 39 of the report) These officers will have to be mobile because his/her activity involves mostly touring and therefore they should be given traveling allowance and loan to purchase two wheelers.

Action:

Regular Government order will have to be issued after obtaining clearance from the Finance Department for the creation of 175 Taluka level Health Promotion and Education Officers. Along with this order, the loan for these officers for purchase of two wheelers should also be sanctioned.

Recommendation – 4

Ideally, there must be one Health Promoter and Educator for every PHC. This requires more than 1600 Health Promoters for the whole State. But there are only 782 Health Educators in the state at present. To cover all PHCs with Health Promoters, it is recommended to attach two PHCs per every Health Promoter and Educator. But, he has to be attached to Taluka Health Office and made to work under the control of Taluka Health Promotion and Education Officer. And additional 273 Health Promoters post may be sanctioned to cover all PHCs. This will ensures one Health Promoters or every two PHCs.

Reason – 1:

Now there are 782 sanctioned posts of Health Educators in the State. Of these, 688 people are working and 94 posts are vacant. Of 688 persons who are working, 217 people have DHE qualification and the remaining 471 people do not have DHE qualification. These people may be posted as Health Promoter and Educator and two PHCs may be attached to each person, thus 942 PHCs can have Health Educators. The vacant posts of 94 may be filled up as soon as possible, so that another 198 PHCs can be covered. Still 545 PHCs will go without Health Promoter and Educator and to cover these PHCs 273 additional posts required to be sanctioned.

Reason – 2:

All India staffing pattern for PHC includes Health Educator. In addition, there must be some person at the grass root level to initiate and take leadership in a very vital area of public health. Health promotion is a process of enabling people to increase their control over the Health determinants. It involves people and host of other public persons. He/she should be in constant touch with village formal and informal leaders to secure their co-operation and use their influence in order to bring about critical social pressure on general public to change their behaviour. People will have to participate in a big and sustainable way to bring about this revolutionary change in the human health behaviour and practice. He is a grass root level worker at the PHC in health promotion and education and a facilitator and an organizer. Unless there is one person with sociology

background with mass communication skill, all efforts made from the top in the field of health promotion and education will be of no avail. Therefore, one Health Promoter and Educator per Primary Health Centre is a must and this staffing pattern should be continued and additional posts may be sanctioned, in a phased manner.

Qualification for Health Promoter and Educator

He/she must have a basic (BA or MA) University Degree in sociology and should have undergone training in health promotion and education. (A six weeks training programme may be arranged for all those who have no DHE qualification and for new recruits before they are posted as Health Promoter and Educator)

Recommendation – 5

All vacant posts in Field Study and Demonstration Units, Audiovisual Unit, Exhibition and Student Health Education Unit should be filled up immediately and the above units should be made functional and energized.

Reason:

These units are essential for any health promotion and education organization. It is in these units innovative action programmes are tested before they are employed on a large scale. They act as field laboratory for pre-testing IEC materials and they are research-cum-action units to give feed

back in concurrent and terminal evaluation of an educational activity. Therefore, all these units may be retained and vacant posts may be filled up. These units are also important for planning, monitoring and evaluation of health promotion and education activities (see also page 34–35 and 53 of the report for further justification)

Action:

Director of Health and Family Welfare Services in consultation with the Health Commissioner, can fill-up all the vacant posts.

Recommendation – 6

Now, the IEC activities are organized by several division like RCH, IPP IX, AIDS, Tuberculosis and Leprosy. It is recommended that all IEC activities should come under the responsibility and control of the Health Promotion and Education Division. This division should implement and monitor all IEC activities.

Reason:

Health promotion and health education is a team activity with special input by Health Promoter both at the implementation level and planning and monitoring level. The division of health promotion and education is staffed with people who have the skill to organise mass education campaigns and group education programmes involving people and there are Administrators at the taluka and district level to over see all IEC activities and give

appropriate guidance. Therefore, all IEC activities of all divisions should be entrusted to the division of Health Promotion and Education to improve efficiency (see also page 55 of the report)

Action:

An executive order from the Health Commissioner is required. Because all programme Directors will have to surrender the funds from their budget to this division for implementation of the health education activities.

Recommendation – 7

Routine health promotion and education programmes should be organized in every PHC covering all villages. All the grass root level workers and their supervisors must be responsible for implementing these activities. These activities must be planned, organised and monitored by the PHC Health Promoter and Educator and supervised by Taluka Health Promotion and Education Officers. Atleast Rs. 5000/- per PHC per annum may be budgeted for health promotion and education.

Reason:

At present there is no organised routine health education activity to perform either by the Health Educator or grass root level health workers except personnel communication to pregnant mothers by ANM and

sponsored IEC programmes which are funded by Central or State funds. This is not correct. This appears to be the reason why Health Educator at PHC are used for other odd jobs by the Medical Officers because he has no routine job to do till a sponsored programme is sanctioned and funds released. The health promotion and education should be a routine Primary Health Centre function. It is the duty of Health Promoter and Educator to plan social mobilization programme, group education programme in every village in the PHC and implement the plan with the help of local grass root level workers and their supervisors. Some funds must be made available for the PHC for health promotion and education activities. The Health Promoter at the PHC may be allowed to raise funds from philanthropists for the programmes. But the State should provide some seed money for the purpose. The programmes like M.S.S. and self-help groups, jathas by school children should become a routine activity in every village. Whoever the sponsored programmes, they should also be implemented as and when there are sanctioned by the state and central governments.

Action:

The Director of Health and Family Welfare Services should send the proposal to Finance Ministry with the concurrence of Health Commissioner and plead with the budget allocators to make provision of atleast Rs. 5000/- per PHC per annum.

The Director of Health and Family Welfare Services should also issue executive order to make IEC activity as a function of the Primary Health Centre and the planning, implementation and monitoring should be the

responsibility of Health Promotion and Education Division. Of course the District Health and Family Welfare Officer and Medical Officers of Health are responsible in their jurisdiction for implementing these IEC activities (see also page 55 of the report for justification)

Recommendation - 8

5 to 10% of the Health Budget of the State may be earmarked for IEC and associated activities in the annual budget. This has been already agreed upon by the Central Health Council a few years ago.

Reason:

IEC activities which involves awareness programme, Advocacy programmes require funds for organization and implementation. These programmes are essential to implement the following suggestions envisaged in the Ottawa and Jakarta Declarations. They are:

1. Raising awareness among the general public about the determinants of diseases and illhealth.
2. Promotion of social responsibility of people about the health of others.
3. Encourage people to participate and take control over the root causes of illhealth.
4. Secure infrastructure for health promotion by motivating people to help build health infrastructure in all villages and towns.

5. Mobilization of resources and public opinion required for health promotion in all cities, towns and villages.
6. Increase community capacity and empower the individual about health promotion and others.

Apart from the above, the health promotional activity involves large number of people and groups and not merely individuals. The health promotional activities are aimed at and deal with apparently healthy people with a view to help them to gain better health and become less susceptible for diseases and thus saving lives, lessen the burden of diseases, and increases productivity. This in the long run help communities to improve their health status, to stabiles the population size by adopting small family norm.

Action:

Health Minister and Health Ministry of the State may be requested to take initiative by putting the proposal before the cabinet and then to Finance Ministry for concurrence.

Recommendation – 9

Advocacy programmes on Health Promotion and Education may be organized throughout the State at various levels. The actors and Clienteles is given below. These programmes should be conducted periodically and should become a annual or bi-annual feature of the Health & Family Welfare Department.

They should deal with appropriate health promotion.

Level	Actors	Clienteles
State Level	1. Director of Health & F.W. Services. 2. Additional Director of Health & FW Services of Health Promotion and Education Division. 3. Joint Director of Health Promotion and Education Dvn. 4. Deputy Director, IEC	1. Policy makers 2. Legislatators 3. Finance Ministry Officials 4. Top level Bureaucrats 5. State level religious leaders 6. Health Professionals 7. Health Researchers
District Level	1. Dist. Health and FW Officers. 2. Dist. Health Promotion and Edn. Officers 3. Dy, Dist. Health Promotion & Education Officers.	1. Zilla Panchayat President and Members. 2. Chief Executive Officer. 3. Local Religious Leaders. 4. Local Legislators and MPs.
Taluka Level	1. Taluka Health Officers. 2. Taluka Health Promotion and Education Officers. 3. Health Supervisors.	1. Taluk Panchayat President and Members. 2. Taluka MLA. 3. Religious Leaders. 4. Local Formal Leaders. 5. Local NGO.
Primary Health Centre Level	1. Medical Officer of Health. 2. Health Promoter and Educator. 3. Health Supervisor.	1. Village Panchayat President & Members. 2. Local Teachers. 3. Local NGOs. 4. Self help Group. 5. Village Health Committee.

Reason:

Advocacy and lobbying have become useful mechanisms for motivation and convincing policy makers and decision makers to take rationalistic view and right decision. These programmes are also needed at implementation level (see pages 16-17 and 49 of the report.)

Action:

Health Commissioner should issue direction to Health Department.

Recommendation - 10

A comprehensive School Health programme should be implemented in all primary and secondary schools in the State.

Reason:

Now primary and secondary education is compulsory till the age of 14 for both boys and girls. Therefore there is every possibility of reaching 90 to 95% of children (upto the age of 14) in the schools. School health programme has become one of the most beneficial health promotion activity not only for the present generation of children, but also for the next generation of parents. Many case studies all over the world have accumulated evidence, to show that school health programme is the most cost effective method of health promotion activity. To be effective, it should

be comprehensive and cover 90 to 95% of the target groups. (see also pages 17-18 of the report)

Action:

Government order may be issued directing the Health Department to draw up a plan of action for implementing a comprehensive school health programme in consultation with the Education Department. Necessary funds may also be made available. There is no need for special staff for the Health Department for school Health services. The existing staff at the PHC or Taluka level is sufficient. However some more Funds are required for building toilets and water supply facilities in every school, which may be sanctioned by Zilla Panchayat.

The existing State level and District level School Health Review Committees may be activated or fresh Committees may be constituted with Education Commissioner as Chairman at the State level and the Deputy Director as Chairman at the district level. The education department is ready to collaborate, but the Health Department is not responding sufficiently to plan and implement a comprehensive school health programme. Medical officers must be made responsible to implement school health programme.

Recommendation - 11

The syllabus for primary and secondary school education may incorporate health knowledge and health practices topics in the curriculum, so as to include all aspects of health, environment, air pollution, population problem etc., and social responsibility of

the individual and of the society for community health, and the need to take into account the equity and social justice to all sections of people.

Reason:

There is great need to add health topics in school curriculum in a graded way from 1st standard to 10th or 12th standards. The knowledge learnt here is important and essential for proper healthy behaviour and develop healthy life style for the entire life span of the individual. It helps children to adopt good health habits and discard bad health habits and practices. Many bad health habits are cultivated in childhood without knowing fully there effects on health. Educated person should know desirable health habits, behaviour and practice them by himself and educate his family. He must be a model to others. Moreover, many personal habits and behaviour associated with good health are formed during childhood, the neglect of which may be the causes of illhealth in adult life or old age.

Therefore, scientific information and rationale behind good healthy life style should be made available to every students then and there, and from the early age. Environment of schools should also be healthfull.

Action:

Education Ministry should give direction to curriculum committees to involve Health promotion and Education Director while making reversion of curriculum for primary and secondary education from 1st to 10th standard. Out line of the proposed curriculum is given in the annexture

Recommendation - 12

Training for District Health and Family welfare Officers and Taluka Health Officers and Medical Officers of Health in health promotion and education may be organised at different levels as follows:

1.	State level	:	Dist. Health & Family welfare Officers
2.	Dvnl. level	:	Taluka Health Officers
3.	District level	:	Primary Health Centres doctors

Duration:	State level	:	2 days
	Divisional level	:	1 week
	District level	:	1 1/2 week

The topics should include all the elements of health promotion and education and rationale behind this movement.

Reason:

District Health and Family Welfare Officers and Medical Officers are the kingpins in the implementation of any public health programmes. Unless they are motivated and takes professional interest in the matter, these programmes cannot be implemented. Therefore, the training of these personnel are very important.

Action:

Health Ministry should issue Government Order and direct the Health Department to plan and implement the training programme as early as possible.

Recommendation - 13

The Government may be recommended to bring about intersectoral coordination and cooperation among all Developmental Sectors of the Government.

Reason:

Health promotion and education is a developmental approach to achieve better health for the people. All developmental programmes have the same goal of achieving better standards of living to all people. Therefore, intersectoral coordination is an essential strategy to achieve health promotion. Further, when more sectors of Government are involved in health programmes the health message spreads and reaches more people and the programme is more likely to succeed than when it is done by one sector.

How it could be done

A Coordinator preferably Joint Director of Health Promotion and Education may be appointed for this purpose. He will have to identify the areas for discussion and coordination needed in implementing a particular development programme, involving health component. He will then arrange a discussion with the respective Departments and the Additional Director of

Health Promotion and Education and other public health experts. (see also page 57-58 of the report)

Recommendation - 14

Government may involve non-government organizations in health promotion and education programmes at all levels

Reason:

Non-Government organizations are another organizational resources available to the government to bring about health promotion of people. The health promotional programmes involves active participation of people, ultimateltely they are the beneficiary of any health programme. The local NGO know the local people better and they can raise additional resources needed for the programme.

Action:

Health Ministry may direct the Health Departments to involve local non-Government organizations to participate in all health programmes in a substantial way.

How it can be done

The concerned Health Department official should give preference to non-government organizations to preside over a function or to inaugurate a group discussion and allow them to talk and discuss the issues and thus encourage them to participate in awareness programmes or advocacy programmes. There must be equal partnership between NGO and

government sector and the management of the programmes must be transparent and open. The NGO also will be helpful to raise additional resources whenever needed.

However entrusting, the sole responsibility to NGO for implementation of an health programme without proper control and check may be counter productive in the long run.

Recommendation - 15

Recommended to the government to make public health qualification like DPH or MD (CM) mandatory qualification for appointment as District Health & Family Welfare Officer.

Reason:

Health promotion is a public health activity. It involves people. It is a social and political action. It envisages a planned activity. The health promotional programmes have to be planned, monitored and evaluated scientifically. Besides, the public health expert should be able to exhibit leadership qualities and should be an efficient manager. To acquire all this knowledge and develop skill one has to undergo additional training and education. A physician after his MBBS degree or with clinical postgraduate degree will have no chance to acquire proper attitude, skill and theoretical knowledge needed to become a technical administrator. Therefore, a public health administrator should have public health qualification.

Action:

Government can change the cadre rules and incorporate the DPH or MD (CM) to be promoted as District Health and Family Welfare Officer.

Recommendation - 16

The syllabus for MBBS course, DPH and MD(CM) may be modified so as to include all the essential principles, strategies and action programme of health promotion and education, so that these professionals should be capable of being community leaders in order to mobilize community participation.

Reason:

The new ideas and new developments in public health and preventive medicine are many and they are increasing every decade. People in the academic field are not so well versed about what is actually happening in the field or community. Community medicine is changing much more than other fields of medicine. Hence, there is need to incorporate these principles in the curriculum of basic doctors and public health experts.

Action:

Rajeev Gandhi University of Medical Sciences Vice Chancellor can direct the Curriculum Committee of the university to consider and incorporate the principles and practicing of health promotion and education in MBBS., MD and DPH courses.

Recommendation – 17

Training for State, District, Taluka and PHC level health education staff should be organized at various levels.

Sl No.	Level	Cadres	Duration
1.	State Level	All State level and District level staff.	3 Days
2.	District Level	All Health Educators in the District with DHE qualification.	1 Week
3.	District Level	For Health Educator without DHE qualification.	6 weeks

Reason:

Health promotion and education process involves more than mere education. The social support and empowerment are additional action programmes that these people will have to undertake to implement health promotion strategies.

Action:

Director of Health and Family Welfare Services can issue order for training of these key officials for health promotion and education.

Recommendation – 18

Health Promotion and Education Division should have the staffing pattern and the top level staff should have qualification and experience as follows:

1. Additional Director of Health and Family Welfare Service

   - Number of posts ... One
   - Status ... Head of the Division of Health Promotion & Education.
   - Qualification ... MBBS., DPH., or MD (CM) should have worked atleast 15-20 years as Health Administrator at the District or State level. Qualification in Communication is desirable.

2. Joint Director of Health and Family Welfare services. One

   - Qualification ... MBBS., DPH., or MD (CM) should have worked atleast 10 years as Health Administrator at the District or State level. Qualification in Communication is desirable.

3. Joint Director of Health Promotion and Education.

   - Number of Posts ... One
   - ... Appointment should be promotion by selection from among the District Health Promotion and Education Cadre. Seniority should be the

criteria unless a person has an outstanding achievement in the field.

- Qualification ... BA or MA in Sociology, DHE and Degree or Diploma in Communication and should have had 10-15 years of experience as District Health Promotion and Education Officer or equivalent post in the Division of Health Promotion and Education.

4. Deputy Director of Health Promotion and Education.

- Number Of Posts ... 4
- ... One for RCH Training

  One for School Health

  One for Non-Communicable diseases & AIDS

  One for Communicable Diseases & Research
- Qualification ... BA or MA in Sociology and DHE and should have not less than 10 years of field experience as District Health Promotion and Education Officer. Diploma or Degree in Communication may be given preference.

5. District Health Promotion and Education Officers

- Number of Posts ... 27 or as many as number of Districts in the State.
- ... By promotion among the

District Deputy Health Promotion & Education Officers.

- Qualifications ... BA or MA in Sociology and DHE and should have had atleast 5 years of experience as District Officers. Degree or Diploma in Communication may be preferred.

6. Deputy District Health Promotion & Education Officers

- Number of Post ... 27 or as many as number of District in the State
- ... Appointment by promotion from among Taluka Health Promotion and Education Officers.
- Qualifications ... BA or MA in Sociology and DHE and atleast 5 years as Taluka Health Promotion and Education Officers

7. Taluka Health Promotion and Education Officers

- Number of Posts ... 175 or as many as number of Taluks in the State
- ... Appointment by promotion from among the Health Promoters and Educators
- Qualifications ... BA or MA in Sociology and DHE and atleast 5 years of experience as Health Promoter and Educator

8. Health Promoter and Educator

- Number of Posts ... 1635 or as many as number of PHCs in the State
- ... Appointment by fresh recruitment from among the applicants.
- Qualifications ... BA or MA in Sociology, DHE qualification or a Diploma or degree in communication may be preferred. Candidates should possess:
  - Good knowledge in Kannada
  - Should possess good communication
  - Should posses good leadership quality
  - Should have good knowledge about the community, group dynamics, Lobbying, negations etc.
  - Preference may be given to people who are living in villages of the respective Districts. The existing Health Educators may be absorbed as Health Promoters & Health Educators and the rest may be recruited

9. Technical Officers

- Number of Posts ... 3

  One for Audiovisual Unit

			One for Field Study & Demonstration Unit
			One for Exhibition Unit
10.	Health Supervisors	...	2
			One of Training Unit
			One for field Study & Demonstration Unit
11.	Nursing Officers/Public Health Nurse	...	2
			One for Training Unit
			One for Field Study & Demonstration Unit
12.	Home Science Asstt.	...	One FS & DU
13.	Social Scientist	...	One FS & DU
14	Teacher	...	One FS & DU
15	Artist-cum-photographer	...	One
16.	Artist	...	One
17.	Sub-Editor	...	One
18.	Projectionist	...	One
19.	Craftsman	...	One
20.	Silk-screen Technician	...	One

Qualification and experience required for the above posts are already existing in the Department, the same may be applied.

The following recommendations have been made to National Governments by a W.H.O. international meeting held in Geneva – 27 - 30 November 1995. They may be considered by the Task Force wherever they are applicable.

- Resource allocation for therapeutic medicine and for public health must be more equitable, and new resources should be mobilized for public health.

- Government should promote, facilitate and support voluntary public health action and community participation in policy development.

- Governments should promote and facilitate intersectoral cooperation in public health. In order to achieve an effective and coherent public health policy, health ministries must recruit the partnership of other departments such as trade, industry, agriculture, housing, public works and so on, all of which have key roles in the development of the new public health.

- Governments should find ways and means to enhance the status and image of public health care professionals consistent with their crucial role in the health of a nation; such status and image should not be less than that of professionals offering predominantly curative care.

- Governments must seek an integrated approach to health, the environment and socioeconomic development and, in the words of the Saitama declaration, "improve solidarity in a global approach to generate, distribute and utilize public resources for sustainable development, promotion of health and protection of the environment."

6th Standard	Chapter 8.	Digestive System - Respiratory – Sense Organs.
	Chapter 10.	Water Pollution
	Chapter 13.	Man and Environment Pollution
7th Standard	Chapter 9.	Water Pollution
	Chapter 10.	Air Pollution
	Chapter 11.	Human Body
	Chapter 12.	Food Health and disease – Nutritious Food – Food habits – Food preservation – Adulterated Food – Habits – Smoking – Drug Addiction – Personal hygiene
8th Standard	Part - II Unit – I	Transmission of microbes from one person to another person – Transmission through water and food – Cholera – Tuberculosis - Tetanus – First Aid – Transmission – Through Animals – Rabies – Immunisation – Pregnant Mother – Infant – Preservation of Food – Food Poisoning
	Unit – III	Hormonal plants – Asthma
9th Standard	Part – I	Unit - I : Ways of living
	Chapter 14.	Human eye
	Chapter 15.	Defects of eye
	Chapter 16.	Colour vision
	Part – II	Unit – I
	Chapter 4.	Life Processes – Digestion in man – Respiration – Transport – Excretion – Reproduction
		Unit – II
		The Story of Man – Evolution in Man
10th Standard	Part – II	Unit – II
	Chapter 5.	Environmental Pollution
	Chapter 6.	Constituents of Food C/F/MV/P/F – Mineral Salt deficiency disease – Anaemia – Goitre – Balanced diet – Food Adultration.
	Chapter 10.	Factors affecting human health – Malfuctiong of Body Parts – Genetic Factors – Hormoal Imbalanced – Allergy – Malnutrion – Pathogens – Viruses – AIDS – Leprosy – Malaria – Kala azar

COMMENTS ON THE EXISTING SYLLABUS AND NEED FOR A CHANGE

The existing syllabus starts from 3rd Standard to 10th Standard. First Two standards are left out. This is not correct. Students when they are admitted to First Standard are already 6 Years old and they are capable of understanding some elementary aspects of human body and environment. More over important aspects of living style should be introduced as early as possible so that scientific information is available to the student before he had any chance of imbibing unscientific view of life style. There fore awareness about health should be started from the 1st Standard itself.

The existing syllabus though includes some aspects of health information the health matter is not sufficient and not scientifically arranged from 1st Standard to 10th Standard and the syllabus is not comprehensive. Syllabus do not emphasize the acquisition of skills, it is not sequentially developed and do not reflect the interdependence of students, peers, the family, and the community. Promotion of health and well-being is not adequately treated. Classroom activities are not supplemented by activities and projects at home and in the community that enhance students understanding of the family and social underpinnings of health.

Further the syllabus do not include any thing about the individual, family, and community responsibility for creating health facilities and maintaining community health which is crucial for learning life skills and acquiring healthy habits.

The principles of education is to arrange syllabus from simple things to complicated things gradually and in increasing sophistication. The subject matter must be repeated at periodical intervals. The syllabus must be taught over an extended period of time and it should be incorporated into the daily life activates of the community. The existing syllabus do not conform to the educational principles. Hence there is need for a thorough change in the syllabus.

REFERENCE:

Report of a WHO Expert Committee. WHO Technical Report Series – 870.

THE NEED FOR COMPREHENSIVE SCHOOL HEALTH SERVICE.

EXPERIENCE OF U.S.A.

U.S.A. is implementing comprehensive School Health Education Curricula and they have found by large scale evaluation studies the following benefits over the years.

1. School Health Education Increases students knowledge of healthy behaviour and risk behaviour.
2. Teacher training in health education has a significant effort on successful achievement of health out – comes for children.
3. "Booster Shots" of health education is necessary every 2-3 years.
4. Significant gains in students knowledge can be achieved after 50 hours of instruction and moderate improvement in students health related behaviour can be achieved after 30 hours of instruction in a topic.

Reference: W.H.O. Technical Report Series 870.

PRINCIPLES AND PRIORITIES OF SCHOOL HEALTH SERVICES

Every school should provide a safe learning environment for students and a safe workplace for staff:

To often the school environment itself can threaten physical and emotional health. The school environment should:

- provide safe water and sanitary facilities;
- protect students from infectious diseases;
- protect students from discrimination, harassment, abuse, and violence;
- reject the use of tobacco, alcohol, and illicit drugs.

Every school should enable children and adolescents at all levels to learn critical health and life skills:

- focused, developmentally appropriate, skills-based health education in topics such as infectious diseases, nutrition, preventive health care, and reproductive health;
- comprehensive, integrated, life-skills education that can enable young people to make healthy choices and adopt healthy behaviour throughout their lives;
- health education that enables young people to protect the well-being of the families for which they will eventually become responsible and the communities in which they reside.

Every school should more effectively serve as an entry point for health promotion and a location for health interventions:

- provide safe and nutritious food and micronutrients to combat hunger, prevent disease, and foster growth and development;
- establish prevention programmes to reduce the use of tobacco, alcohol, and illicit drugs, as well as behaviour that promotes the spread of HIV infection;
- treat, when possible, helminth, malarial, skin, and respiratory infections, as well as other infectious diseases;
- identify and treat, when possible, oral health, vision, and hearing problems;

- identify psychological problems and refer those affected for appropriate treatment.

The community and the schools should work together to support health and education:

Families, community members, health service agencies, and other institutions have an important role to play improving the health of young people. At the same time, the school can play an important role in improving the health of the community as a whole. Such roles include:

- advocacy and support by the community for the development of the school as a healthy organization;
- active consultation and collaboration between families, the community, and the school to improve the health of children and adolescents who attend school, as well as those who do not;
- active participation by the school and its students in programmes to improve the health and development of the entire community.

School health programmes should be well designed, monitored, and evaluated to ensure their successful implementation and their desired outcomes:

- developing or adopting in each Member State the most appropriate and affordable methods to collect data about children's health, education, and living conditions, by age-group and sex;
- emphasizing, whenever possible, research that draws on the knowledge and skills of local educators, students, families, and community members;
- developing methods for the rapid analysis, dissemination, and utilization of data at the local level, where they can have the greatest impact.

FOCUS

ON SCHOOL HEALTH EDUCATION

1. School Health Education (S.H.E.0 will Focus on behaviour and conditions that promote health.
2. Help Children to develop life skills needed to adopt healthy behaviour.
3. Inculcates knowledge, attitudes, believes and values related to the development of healthy behaviour and health promoting conditions.
4. It will provide learning experience that allow students to practice skills and model behaviour.

ECONOMICS OF SCHOOL HEALTH SERVICE

There is ample evidence that school health expenditures result in substantial savings:

- A study in the USA estimated that every US $1.00 invested in schools on effective tobacco education saves US$ 18.80 in the costs of addressing health and non-health problems caused by smoking. The study further estimated that the benefit of every US$ 1.00 spent on education for alcohol and other drug abuse prevention saves US$ 5.69. Furthermore, each US$ 1.00 spent on education to prevent early and unprotected sexual behaviour saves US$ 5.10. On average, the money saved by society for each US$ 1.00 spent on these three forms of health education is approximately US$ 14 (1).
- Spending money on school health programmes can be justified on purely economic grounds; schooling pays off in higher incomes and a healthier workforce. (2).
- A 1993 World Bank analysis (2) estimated that most regions of the world could greatly benefit by implementing an "essential public health package" consisting of the following five central elements:

  - an expanded programme on immunization;
  - school health programmes to treat worm infections and micronutrient deficiencies and to provide health education;
  - programmes to increase public knowledge about family planning and nutrition, about self-care or indications for seeking care, and about vector control and disease surveillance activities;
  - programmes to reduce consumption of tobacco, alcohol, and other drugs;
  - AIDS-prevention programmes with a strong component on other sexually transmitted diseases.

Although school health programmes are explicitly mentioned in only one of the above elements, for a large portion of the world's population, schools could efficiently provide all five elements of the recommended package.

There is ample evidence that better health improves academic performance:

Throughout the world, there are many examples of the school-based treatment of medical problems resulting in improved academic performance. In one, Jamaican children who were treated for moderate whipworm infections raised their test scores, which had lagged by 15% up to the level of uninfected children (2). School food programmes also have a marked effect on attendance and school performance (3).

There is ample evidence that school-based programmes can reach very large populations of school-age children:

- Schools can reach about one billion students worldwide and, through them, their families and communities. As previously noted, "the formal education system is . . . the developing world's broadest and deepest channel for putting information at the disposal of its citizens" (4).

- School health programmes have improved the health of large populations when implemented on a national scale. In the Republic of Korea, for example, the prevalence of intestinal helminthes among children was reduced from 80% to 0.2% over 30 years through a school-community chemotherapy, health education, and sanitation programme.

- Teachers can have an immense impact on young people's health. As reported by UNESCO, there are almost 43 million teachers around the world at the primary and secondary levels (23.9, primary; 18.8, secondary) (2). The size alone of the teacher population is of public health significance.

There is ample evidence that health education and services have far-reaching effects:

- Studies in the USA have documented that carefully designed and implemented comprehensive health education curricula can prevent certain adverse behaviour, including tobacco use, illicit drug use, dietary practices that cause disease, unsafe sexual behaviour, and physical inactivity. Further, such curricula reduce school absences by reducing the impact of disease and drug and alcohol abuse, and the number of injuries and unintended pregnancies; they also improve cognitive performance through proper diet, exercise, sleep, and stress reduction (5).

- Healthy habits learned during early years (e.g. safe food handling) will be applied throughout life (6).
- School-based clinics show evidence of improving students' knowledge about how to be effective consumers of health services, reducing substance abuse, and lowering hospitalization rates (7).
- Health promotion for school staff, one of the least visible elements of school health programmes but one of the most critical, can decrease teachers' absenteeism and improve their morale and the quality of classroom instruction (8). One programme for school staff in the USA demonstrated reductions in body weight, resting pulse rate, serum cholesterol level, and blood pressure (9).

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Strategic Planning of School Health Programmes – from problems to action

Published research on how schools change and accommodate innovation provides convincing evidence that producing change in schools and communities is a long, necessarily local, and evolutionary process that must involve the entire system. So-called "quick fixes" do not work; the implementation and institutionalization of reforms often take 20 years. According to new international study of the process of change in educational reform, successful reform has three main ingredients:

- a well planned and evolving national commitment, made concrete through appropriate management practices and institutional support, sustained over at least 10 years:
- strong local capacity;
- coherent linkages between central, district, and local school levels, by means of information, assistance, pressure, and rewards.

The Strategies are:

- To promote public policies for school health that provide resources.
- To foster supportive environments that are the result of assessment and improvement of the physical and psychosocial environment of the school.
- To encourage community action that supports the process of health promotion and the linkages between the school and other relevant institutions.
- To promote personal skills development (through both curriculum and the teaching and learning process) that emphasizes specific health-related behaviour, as well as the skills need to sport health throughout life.
- To reorient health services.

  - provide enhanced access to services within the school as well as referral to the external health system;
  - identify and implement specific health interventions that are best carried out through the school;
  - integrate curative and preventive interventions.

TEACHERS TRAINING

Training for school personnel is an important aspect of school health promotion programmes. Studies show that training teachers in the use of a health education curriculum improves their implementation of it (1).1 Teacher training also builds the commitment, understanding, skills, and attitudes that enable teachers to use curricula effectively and confidently. A complete training programme should have the following five broad goals:

- for teachers to have an appropriate understanding of the human organism and causes of disease and injury;
- for them to develop positive attitudes towards and commitment to a comprehensive approach to school health;
- to increase their understanding of the principles of behavioural change that are effective in health education;
- to improve their teaching skills in areas such as class discussion, role playing cooperative group activities, small-group discussion, community-involvement activities, family-communication activities, games, and simulations;
- to prepare teachers to deal with sensitive issues and refer students with additional needs.

Implementation issues

Training for teachers, supervisors, and school administrators can be offered for curriculum development, the provision of school services, and improvement of the school environment, as well as in specific content areas.

Successful teacher training:

- addresses issues of concern identified by teachers;
- is conducted as close as possible to teachers' work plances;
- covers theory and demonstration, includes practice teaching offers feedback on performance, and emphasizes peer-coaching skills;
- has the support of both teachers and the school administration;
- enables participants to feel a sense of ownership of the programme;

- uses adult-learning theory;
- is conducted over an extended period of time;
- provides opportunities for reflection and feedback;
- involves a conscious commitment by participants;
- builds specific skills;
- works with groups rather than with individuals.

Strategies

The Expert Committee noted that accepted recommendations for teacher training include the following:

- teacher training should be reviewed and upgraded at pre-service, in-service, and continuing-education levels;
- teacher-training programmes should ensure that student teachers receive field experience;
- routine workshops seminars, and short courses should be carefully designed and implemented;
- health teachers and staff as well as non-teaching school personnel should be trained;
- mechanisms for continuing education and supportive supervision to maintain and enhance the quality of teaching should be developed (2).

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RECOMMENDED OUTLINE OF CURRICULUM ON HEALTH FOR PRIMARY AND SECONDARY SCHOOLS – FIRST STANDARD TO TENTH STANDARD.

Goal and Objectives

GOALS

To enhance the promote health knowledge and health practices of school going children in every possible manner to enable to adopt measures to achieve positives health and remain healthy and to develop in them a self reliance and social responsibility and better quality of life not only as children, but also as adults and parents of tomorrow.

OBJECTIVES

1. To create health consciousness and make them understand that health is most precious possession and resources to realize the genetic potentialities of every child.
2. To make them realize, that he, his parents family and community are primarily responsible for his and community health.
3. To help him to acquire healthy habits, healthy behaviours and healthy life style as he grows learns, and develop through out school going years.
4. To inculcate a sound scientific through as to root causes of diseases and disability in man and rational of prevention of diseases and prevention of promotion if health.
5. To make him realize the unnecessary burden of health care expenditure resulting from negligence and not preventing preventable illness and disability.
6. To make him realize his and community responsibility towards the community and need for tearful, and wholehearted cooperation and achieve participation in creating and maintaining health infrastructure in any human settlement.

TOPIC AND AREAS OF STUDY INCLUDED IN THE SYLLABUS

1. Human Biology, Anatomy, Physiology, Growth and Development, Heridity and Genetics.

2. Human Sociology and Psychology, Individual, Family and Community, socialization, Interdependence; Friends; Peer groups; Social behaviour; Psychological factors; and Mental Health.

3. Human Nutrition and Health.

4. Human environment, Physical-Environment, Biological environment and social environment, Role of the individual and community in creating and maintaining health environment.

5. Concept of health, Root causes of illhealth and promotion of health.

6. Concept of diseases, communicable and non-communicable diseases and their control – role of individual and the local community in control and prevention of diseases.

7. Responsibility for health of the individual and the community and family. Community organizations local self government, State and Central Governments. Village and ward Health Committees.

8. Accidents – home accidents, road accidents – Calamities – First Aid.

9. Common illnesses among infants – children – Adolescents and adults – Home Remedies, proper use of common drugs.

10. Reproductive and Child Health and adolescent health.

11. Demography and Population.

12. Health Care System – Health care infrastructure – School Health Service.

13. National Health Programmes.

14. Health and Medical Care Institutions.

15. Voluntary Sector for Health Promotion and protection of community Health.

16. Role of the individual and community in creating and maintaining health facilities and health behaviour of people, in the local area.

STANDARD – I

1. Knowing the external parts of the human body and their functions. Writing their names and functions.
2. Knowing the role of parents in growth and development – writing the Names of parents – Family Tree – peer groups and their functions.
3. Making a list of Teachers and their role in learning and better Health.
4. Making a list of friends and need for interaction with friends and peer groups for better health.
5. Making a list of food articles used at home.
6. Classification of foods – Body building, energy yielding and protective foods.

ACTIVITIES:

1. Teachers weekly observation and Record.
2. Drawing the external parts of the body and labeling them.
3. Health appraisal by Doctor. Every Child should be examined by the doctors only.
4. Maintain Health Records.

STANDARD – II

1. Method of caring for the external parts of the body – Washing – Bathing - Wearing footwear – Change of Clothing – Use of cleaning agents – Local and Home made materials.

2. Knowing the internal systems and their functions of the body – Skeleton system – Circulatory – Respiratory & Excretory systems.

3. Human being as a social animal – need for family – parents – friends for healthy growth and development.

4. Quantity of food required for different age, sex and occupational groups.

5. Healthy and Protective foods. Hand pounded rice – Germinating Grams – Leafy vegetables – cooking of food to preserve nutrients and safety – Use of left-overs – food poisoning.

6. Physical Environment of Man: Water – Sources – Pollution-diseases transmitted - Purification of Water - Domestic purification – There is no need for bottled mineral water except during tours and excurtion.

7. Biological Environment of man: Rodents – Dogs – Cattle, Housefly and Mosquitoes.

8. External Parasites of man: Louse – Scabies – Mode of Spread and Prevention and personal Hygiene.

9. Good & Bad Health habits & Health behaviours – Avoidance of Alcohol – Smoking – Chewing tobacco.

ACTIVITIES:

1. Writing the Skeleton of Human body and Labeling.

2. Drawing the Circulatory and Respiratory systems and Labeling.

3. Teachers Weekly examination for cleanliness, early symptoms of illness.

4. Daily play and Exercise.

5. Health Appraisal by Health Assistant.

6. Parents report on Health habits and Healthy eating habits.

STANDARD – III

1. Knowing the digestive and Nervous systems of the body and their functions.
2. Social system and Social life in villages – Wards – Towns and Cities.
3. Quality of food – Balanced diet – uses of Milk, Vegetables – Eggs – Meat.
4. Solid and Liquid waste produced by human activities at home - Disposal from houses – Soak pit – Compost – Garbage disposal.
5. Housefly – Breeding places – Life history - Diseases spread – control.
6. Meaning of Health and Diseases.
7. Factors that determine Health.

ACTIVITIES:

1. Excursion to show the physical environment – Demonstration of Housefly breading places.
2. Weekly Teachers observation and Record.
3. Parents Report.
4. Health Appraisal by Health Assistant and identification of departure from normal growth and development of habits.
5. Cleaning the Class Room.
6. Daily Exercises.

STANDARD – IV

1. Knowing the various digestive glands and their functions.
2. Socialization – Love – Affection – Hatred, Jealousy.
3. Malnutrition – Grades – Deficiency – Vitamin A and Vitamin C and ways to prevent by using fruits and vegetables – Vitamin A Supplement.
4. Mosquitoes – Breeding Places – Life History – Diseases spread and control.
5. Physical Environment around the school and houses – Drains – Ponds – Water collections and their effect on health.
6. Common communicable diseases in the locality – Method of Spread and prevention.
7. Accidents – Home – Traffic.
8. Primary Treatment for common cold – Fever – Respiratory Tract infections – Diarrhea.

ACTIVITIES:

1. Excursion to show drains – Ponds – Mosquitoes breeding places.
2. Demonstration of Housefly and Mosquitoes and their eggs and Larvae.
3. Teachers observation weekly and scrutiny of parents report.
4. Health appraisal by Health Assistants.
5. Physical Exercise.

STANDARD – V

1. Coordination between various systems in the body – Functioning of the body as a whole – Refractive Errors – Hearing defects Hormones and their functions.

2. Growth and Development - Physical growth of infants - Toddlers – Adolescent Spurt. – Developmental Mile-Stones.

3. Friends – Relatives – Interaction with them – Behaviours – Society norms – Adjustability – Tolerance – Avoidance of Stress.

4. Healthy eating and Learning habits – Cultivation of good habits and avoidance of bad habits.

5. Use of Vegetables and other nutritive foods. – Avoidance of Chocolates – Other tasty bites which are injurious to health.

6. Domestic Animals – Pet and Street Dogs – Diseases spread by dog bite.

7. Common cold – Fever – Cough – Diarrhea – their management at home.

8. Avoidance of Unnecessary medication. And use of simple bed rest – Aspirin or paracetamol – oral Rehydration for diarrhea.

9. Routine Immunization Schedule for children.

10. Sanitary disposal of Human excreta – Toilets at home – Suitable in villages – Towns – Cities.

ACTIVITIES:

1. Excursion to show the open air defecation – Soil Pollution – How the fecal matter enters the food chain.

2. Writing the Health Needs of the Human being.

3. Teachers observation weekly.

4. Health Appraisal by Doctors.

5. Review of the Health Record by Health Assistant – Report to the Doctor – Doctors Advise and follow-up.

STANDARD – VI

1. Knowing the Human Reproductive system and function.
2. Primary and Secondary Sexual characters and Health Problems of Adolescent.
3. Social behaviour – Social Values - Role of Individuals in creating and Maintaing community health.
4. Group living – Group Activities – Play – Aggressiveness – Isolation and with drawing behaviour – Courage and boldness. Mental health.
5. Malnutrition – Grades – Iron and Iodine deficiencies – Root causes.
6. Community water supply – Deep wells shallow wells – Ponds and tanks as sources water.
7. Common Non communicable diseases – Diabetes – Hypertension – Cancers – HIV/AIDS.
8. Healthful house minimum requirement for health of a family – Danger of cattle Shed with in the dwelling house.
9. Growth of population and population explosion – Need for limitation of population growth small family norm.
10. Health care System in the village – Primary Health Centre – Sub-Centres and their functions.
11. Ignorance – Superstitions – Rituals – Poojas – Need to know the effects of these on health and the scientific view of the causation of disease .

ACTIVITIES:

1. Visit to primary Health centre or subcentre and learning the uses of doctors and Health assistants in maintaining health.
2. Measurement of Height and Weight of Friends – Keeping their own Health Records.
3. Arranging group discussion and seminars on environment – Food – Water.
4. Teachers observations.
5. Health Appraisal by Health Assistant.

STANDARD – VII

1. Endocrine glands and their functions.

2. Heredity – Genetics and Genetic disorders.

3. Occupation and Health – Factory – Small Work shops – Hotels – Abuse of child labour.

4. Habits dangerous to Health – Alcoholism – Smoking – Use of Drugs – Chewing Tobacco – Their impact on Health – Social problems.

5. Mental Health Problems – Recognition and counseling – Parents interaction.

6. Air and Noice pollution – Impact on Health.

7. Cardiovascular diseases – Role of Diet – Exercises. – Smoking and stress.

8. Reproductive and Child Health – Age at Marriage – Age at Pregnancy – Child Birth – Safe Delivery – Low Birth Weight babies – Antenatal and Natal Care – Food and Health Care of Mother during pregnancy and lactation.

9. School Environment – Need for Toilets – Separate for boys and Girls – Drinking Water – Sufficient Play Ground.

10. Role of the panchayet – In maintaing Healthy Environment in and around the Villages – Slums – Towns.

ACTIVITIES:

1. Taking part in Health Examination of Lower grade students – Measurement of Height and Weight – Taking Pulse Rate – Eye Sight Examination.

2. Taking part in Health Teaching of Lower Classes – Pupil to Pupil Teaching.

3. Arranging debates on population – HIV/ADIS – Social Behaviour – Moral Restraints – Superstitions – Wrong and dangerous beliefs – Scientific Temper.

4. Health Appraisal by doctors.

5. Review of follow-up measures by health assistance.

6. Parents report on Social Habits and Health Habits and counseling if required .

STANDARD – VIII

1. S.T.D. HIV/AIDS – Mode of spread and prevention – Moral restraint.
2. Family – Family Norms – Family Controls – Sexual mis behaviour – Crimes – delinquency.
3. Responsible parenthood – Sex education Family Size – Spacing of children.
4. Food Adultration and Food Preservation.
5. Sanitation of Public Places – Temples – Bus & Railway Stations – Jatras – Shandys – Play grounds and schools.
6. Measurement of diseases in the community – Prevalence Survey.
7. Mortality and morbidity rates.
8. Secondary and Tertiary Health Care.
9. Health Needs of Infants – Toddlers – Handicapped – Sick – Old People.

ACTIVITIES:

1. Taking part in teaching Health to lower class children.
2. Helping in conducting school health services by health assistant.
3. Measurement of pulse and blood pressure.
4. Practice of First Aid Activities.
5. Conducting debates, seminars group discussion on health and social issues.

STANDARD – IX

1. Health Assessment of the Individual.
2. Health Need Assessment of the Community.
3. Important National Health Programmes – Role of the People in implementing them.
4. Village Health – Ward Health Communities.
5. Training of Dais on Safe delivery.
6. Anganawadi Kendars – Their function and management.
7. Family planning – Family Welfare – Family Planning Methods.
8. Role of Men and Women in Family limitation.

ACTIVITIES:

1. Visit to Anganawadi Kendars and Knowing the functions.
2. Visit to Health Centre and Subcentre and Knowing the facilities for safe delivery.
3. Help in Health Teaching.
4. Participating School Health debate, Seminars and group discussion.
5. Health Appraisal by Health Assistant.

STANDARD – X

1. Voluntary Health Organization – Principles of Voluntary Health work – Social Services – Need for Voluntary Organization for Health Care.

2. Private – Public Health Care Services.

3. Minimum Health Care Facilities in villages – Tows – Diagnostic facilities.

4. Peoples participation in organizing and managing health care services like Immunization – Antenatal care – Health Awareness campaign.

5. Identification and Management of Pulmonary Tuberculosis – Leprosy – Malaria – Diabetes – Hypertension – At home following the doctors consultation.

6. Poverty – Employment – Education and their relationship to health.

7. Equity and Empowerment of Weakers sections of people for better health of the community.

8. Right to health – Constitutional Provision and States Responsibility.

ACTIVITIES:

1. Conducting W.H.O. Day on 7th April.

2. Helping School to conduct seminars, symposia on health.

3. Helping Teachers and Health Assistant to conduct Teachers observation and Health Assessments.

4. Giving Health Talks to Children and Public People.

5. Health Appraisal by Doctors.

6. Review of His/her Health Through School years – Report by Health Assistant.

International Union For Health Promotion and Education
South East Asia Regional Bureau
KARNATAKA CHAPTER

590, 10th Main, 5th Block, Jayanagar Bangalore – 560 041.

Dr. K. Basappa, MBBS., DPH., Dr. P.H. (USA)
Professor of Community Medicine (Rtd)
President, Karnataka Chapter-IUHPE.,
And Head of the Research Team

Dear Doctor

As you know, the Government of Karnataka have appointed Task Force on Health and Family Welfare, headed by Dr. H Sudarshan. They are in the process of formulating their recommendations for strengthening the Health Department by way of increased inputs like manpower and other essential resources. The Task Force have a high opinion about the history of Karnataka State Health Department and its superiority and efficiency and as such they want to recommend to the Government to expand the activities of public health and to cover the health promotional area in addition to disease prevention and disease control programmes, in a substantial way. Health promotional area is a broad area which requires action on health determinants and which goes beyond Health Sector alone. Therefore, they wanted the International Union for Health Promotion and Education to take up a Rapid Assessment of the "feasibility and modalities of application of principles of health promotion and integrating it with the Health Education". We have accepted the assignment.

To do the task efficiently, we need the opinion and expertise of people of your eminence and therefore. I request you kindly to give some of your time and thought and help us to provide data for realistic and implementable recommendations.

I have enclosed a list of documents and data to be provided from your division for information and analysis.

I have also enclosed herewith copies of letters from the Director of Health and Family Welfare Services and Dr. H. Sudarshan's letter addressed to the Secretary to Government, Health and Family Welfare Department for your information and reference.

You are requested to participate in the interview that the research Team is conducting for furnishing your expertise and opinion on the matters. Your individual opinion and comments will be kept confidential and will not reflect in the research report.

I hope, you would appreciate the need for your participation and cooperate with the Research Team to complete the task early.

With kind regards,

Yours sincerely,

Dr. K. Basappa

OPENENDED QUESTIONAIRE FOR HEALTH ADMINISTRATORS AND SPECIALISTS.

MARK: Strongly Agree (SA), Agree (A), Agree with Reservation (AR), Do not Agree (DA), against each statement.

1. Health Education should be one of the important activity of the Health Department. .....
2. Health Education is a process of changing the health behaviour of people. .....
3. Health education is only imparting health knowledge to people. .....
4. Change in health behaviour requires series of steps which involve awareness, motivation, interest, evaluation, persuation, peer group approval, approval of parents, partners before adoption .....
5. To bring about the change in behaviour in certain areas for example family planning requires the approval of religious leaders, formal and informal leaders in the community .....
6. Change in behaviour can be brought out easily if all the people in the same social circle agree upon the idea. .....
7. Health behaviour is picked up quite early in childhood and infant by parents own action and couple and peer group action etc. For example, smoking, alcohol, personal hygiene practices. Therefore formal school health programmes are essential. .....
8. Health behaviour for small family norm is favourable, if their parents have small family and not so favourable if their parents have large family. .....
9. State and District level Health Education Programme should be planned. .....
10. While planning, all the people concerned with implementation should be involved. .....
11. For purposes of planning, a group consisting of all interested sectors should be formed well in advance and entrusted the job of planning and prepare the draft plan. .....
12. Draft plan prepared by the group should be discussed by all the heads of different divisions and the final draft should be agreed upon like RCH, Malaria, AIDS etc. .....
13. State Health Education programme should be flexible so as to include local difference at District or P.H.C. level. .....

Contd....2

14. Health Education programme should include general and specific subjects. .....

15. Health Education is the job of Health Educator. .....

16. Health Education is the job of all health staff of the PHC/Hospital/Institution. .....

17. Experts say that any Health Education programme should take into consideration the level of education, attitudes, beliefs, socio-cultural aspects existing practices, misconceptions, traditional beliefs etc. .....

18. Contents of health education should include the activities that encourages the positive health like, good nutrition basic sanitation, Reproductive and Child Health, favourable life style, small family norm, higher age of marriage and higher age of 1st pregnancy and the like. .....

19. Contents should also include conditions or disease specific subjects like Immunization, Malaria, Leprosy etc. .....

20. Health Education is not merely imparting scientific knowledge to people, but also includes to equip the people with skills and attitude to enable them to solve their health problems by their own action and efforts. .....

21. Health Education also include to promote the development and proper use of health care services. .....

22. At the grassroot level community participation is the key for success of health education programme. .....

23. Community participation should start from the planning, finding resources implementation and evaluation of the programme. .....

24. In programme planning, every thing should be left for the people, the Health Educator should act as a stimulator or initiator and as a guide to them. .....

25. Awareness creation about the needs and problems about health in the people's mind is the first step and demand generation is the 2nd step for any successful health education programme. .....

26. To bring about the change in behaviours or accepting and practicing new behaviour a kind of social pressure has to be built up in the community. .....

27. Health education programme can be made sustainable in every community/village/group by forming grassroot level Health Education Committee headed

Contd...3

by public spirited person in the local area and socially concerned persons as Members. .....

28. Health Committees should as far as possible exclude village panchayat members and Chairmen as this is likely inject the local politics. Health Committees should be non-political, voluntary organizations. .....

29. Members of the Health Committees should be given training and retraining in the form of Workshop or Seminar at Taluka level. This is important to keep them their knowledge uptodated and keep them encouraged to do social work. .....

30. Holding Wokshop or Seminar for Health Committees should be one of the functions of health services. .....

31. Health education pogrammes should be organized at group level and at community level to create awareness and demand generation and at individual level to synthesize and change the behaviour for better health/small family norm. .....

32. Social mobilization is an important aspect of health education programmes and sufficient funds must be made available for the purpose in the Health Services budget. .....

33. All modern media like, films, radio, television, printed posters, flipcharts and also folk media like street plays, folk songs, dramas etc., should be used in health education programmes and adequate financial provisions should be made in the health budget of the PHC. .....

34. a) Health Educator at the PHC level should be responsible for carrying out health education programme at the community and group level.

b) But the programmes are not fully successful because there is no sufficient funds, transport and equipments for implementing the health education programmes effectively. .....

35. One Health Educator for 30000 population or per PHC is sufficient to carryout the health education programme .....

36. The knowledge and skills of Health Educator with DHE qualification is sufficient to carryout the social mobilization activities and to ensure community participation. .....

37. All Health Educators posts must be filled up only with DHE qualified persons. .....

Contd....4

38. District Health Education Officers are responsible for administration, direction, guidance and evaluation of the programmes. .....

39. The lack of success and low performance of the district in health education field is attributed to (a) lack of trained staff (b) lack of supervision and guidance (c) lack of funds and equipment (d) combination of all. (tick the true one in your opinion). .....

40. To improve the programmes and quality and effectiveness of health education programmes as a short time measures, the existing Health Educators or persons working as Health Educators should be given short term training in social mobilization and community organization and as a long time measure all Health Educators to be qualified with DHE. .....

41. Effectiveness and quality of education programme can be accelerated by strictly adhering to the advance programmes, surprise visits and proper management measures and concurrent evaluation of the programme by DHEO. .....

42. DHE qualified persons can carry out the health education activities more effectively and efficiently than others. .....

43. DHE syllabus requires change to include more knowledge and capacity building activities for social mobilization work and ensure community participation. .....

44. There is complete coordination between the health education wing and general health services. .....

45. Central Health Education Bureau is helpful to implement the health education programmes in the State. .....

46. a) Government of India has accepted to adopt Health Promotion as a public Health Policy as recommended by Jakartha Declaration and has made ambitious commitment for a global strategy of Health for All (HFA) and to the principles of Primary Health Care through Alma Ata Declaration. This requires enormous resources and additional responsibility on Health Sector, because the main action is to tackle the determinants of Health. Through Advocacy, Social Support and Empowerment.

b) This Policy change in very good and if implemented will improve health status substantially. .....

Contd....5

47. Five strategies suggested for achieving the objectives of Health Promotion are:

1. Build Healthy Public Policy.
2. Create supportive environment.
3. Develop personal skills.
4. Strengthen community action.
5. Reorient health services.

These strategies requires concerted efforts and goes beyond health care services and is on the agenda of policy makers in all sectors and at all levels. The health sectors in addition to reorienting its own services, should be able to influence policymakers of other sectors to be aware of health consequences of their decisions and to accept their responsibility for health. This is possible by well coordinated intersectoral coordination at the State level, at the District level and at the Grassroot level.

1. It is possible to take the additional responsibility within the existing staffing pattern of Health Department.
2. It is possible only with additional staff at the top level.
3. It requires additional staff at the District and PHC level also (tick the appropriate one in your view).
4. In addition to additional staff, it quires stronger attention to health research as well as changes in professional education and training of the existing staff both at State, District and PHC levels.

.....

48. For implementation of Health promotional Strategy the Medical Officers at the P.H.C. Level should also be competent and equipped with organizational and administrative skills.

.....

49. The existing curriculum of community medicine at the graduate level (MBBS) is not sufficient to provide needed impact on the minds of medical students and required additional theoretical background and practical demonstration at the field level.

.....

50. The syllabus of community medicine includes the elements that impart knowledge and skills but it is not properly implemented due to lack of trained man power in the department of community medicine in all medical colleges.

.....

Contd.....6

51. The teaching of social sciences including sociology, health economics, health development, social mobilization techniques should be strengthened in community medicine, at MBBS, level and DPH level. .....

52. To achieve the above, the present medical education module should include socio economic, cultural and behavioural sciences and management sciences in a substantial way and in depth, for both MBBS & DPH. .....

53. In addition the present Medical Officers of Health should be given short term (Two weeks) courses in the above area particularly in management of health programmes like planning, supervision and evaluation of programmes. .....

54. Diploma course for DPH qualification should be of two years duration & syllabus should include more of socially, economics administration and management. .....

55. The post of District Health & Family Welfare officers should be filled up only people with at least DPH. Qualification. .....

56. For successful health promotion, the countries should adapt the principles of New Public Health and strategies and implement them sincerely.

57. Health promotion as suggested above, requires strategies to be planned and implemented at all levels of public health organization, that is at State, District and PHC levels.

58. Health promotion cannot be achieved only by filling up the vacant posts of Health Educators at various levels.

59. Health promotion certainly cannot be achieved by application of computer technology.

60. Health promotion is something that requires very high investment in money and manpower resources.

61. For health promotion, money resources can be found from local resources and international funding agencies.

62. Main stumblic block for successful health promotion, action will be the lack of committed manpower, as on today.

63. Public health workers should spearhead the initiative to involve communities in the development of their public health policies and programmes.

64. Among the public health workers, it is the Health Administrators at the PHC, District and State level who should take initiative both in Public Advocacy and social mobilization.

65. Public health expert should give strong leadership and involve himself for the cause of public health improvement of his country.

66. It is the lack of strong public health leadership and commitment that is at the root cause of present low status of public health.

67. Public health organization in Karnataka State is a well-knit organization with the Director of Health Services as the chief executive assisted by Additional Directors/Joint Directors as Programme Directors including one for Health Education and Divisional, District and PHC level health administrators.

68. The existing public health organization is capable of implementing the health promotional policies and programmes.

69. Resources for public health education and social mobilization is not difficult to obtain, because the international funding organizations like World Bank is eager to fund as has been seen in AIDS, RCH and Water Supply and Sanitation programmes in Karnataka State.

70. There is urgent need to strengthen the State Public Health Services Department with public health experts with strong leadership capacities and capabilities.

71. In recent years, in the State of Karnataka as well as in the Centre, there has been growing sense that public health as profession, as a governmental activity and as a commitment to society, is not fully supported.

72. The role and mission of public health for health promotion should be clearly defined and adequately supported to achieve the goal of Alma-Ata declaration of primary health care and H.F.A.

73. In the long run, the postgraduate courses in the community medicine must produce public health experts who could give strong leadership and put health promotion in the forefront. There is need for restructuring and reorienting postgraduate medical education in community medicine.

74. The report of an international meeting held in Geneva 27-30 November 1995 on "New Challenges for Public Health" has made the following observation. Please give your opinion whether you agree or not, if agree, how strongly about the relevance of these observations about the Indian Public Health.

75. The concept, practice and importance given to public health by highest decision making people are important for implementation of health promotional strategies.

76. One of the major barriers for implementing the health promotional strategies is the lack of properly trained public health experts at the highest decision making level and at the middle planning and implementation level.

77. The criticism is that public health practice has swung too far from its original sanitary orientation and become too disease oriented. For example, the dominance or risk factor model of disease.

78. Public health often remained on the periphery of academic medicine and is desperate need of recognition.

79. Public health has become isolated both from scientific advances and from efforts to organize better health systems. And this has relegated public health for a secondary role in areas if its application generating a vicious circle between isolation and irrelevance.

80. Public health research is not making the necessary contribution to public policy, because of its tendency to want to be seen as excellent rather than any relevance to the needs of public policy.

81. Most public health professional and clinical professionals working in public health positions in the country have little training in wider aspects of health. Their exposure to relevant social sciences and have had little opportunity to learn from role model how to address the social, economic and political forces affecting health.

82. Community medicine or public health research and training should be relevant to the growing complexity of their surroundings.

83. Policy makers in public health and health professionals should meet regularly to review the health problems and research evidence available for their decision making.

84. Many health researchers are ignorant of key issues and developments in the health policy.

85. WHO advocates radical change with respect to curricula of postgraduate courses in community medicine to include subjects to understand the New Public Health a focus on the health of the population on a global and social model of health and health gain.

86. Management training of public health workers is seen as lacking in the developing countries.

87. There is need for synthesis between public health training and health management training.

88. Public health managers and administrators require a combination of specialist clinical skills and general management skill, combination of these skills in a group of individuals will be vital in the future in meeting the challenges posed by health care system and by policy makers.

89. In addition, the public health specialist needs skills in communication, public policy analysis and development also.

90. Social programmes (this includes health) are operating under ever tighter resource constraints. Therefore, the contribution of good health to socio-economic development must be convincingly demonstrated if adequate and sustainable resources are to flow to the health sectors.

91. Resource allocation for public health must be more equitable consistent with its contribution to social development and new resources should be mobilized.

92. The Governments should find ways and means to enhance the status and image of public health care professionals consistent with their crucial role in health of the Nation.

93. You can suggest any thing you deem fit, on the subject under discussion.

☎ : 080-2870943,
e-mail : dir_hfw@kar.nic.in
gvnagaraj_dr@usa.net

GOVERNMENT OF KARNATAKA

ಡಾ|| ಜಿ.ವಿ.ನಾಗರಾಜ್ ,
ಹೆಚ್ಚುವರಿ ನಿರ್ದೇಶಕರು

ನಿರ್ದೇಶನಾಲಯ, ಆರೋಗ್ಯ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಸೇವೆಗಳು
ಆನಂದರಾವ್ ವೃತ್ತ, ಬೆಂಗಳೂರು - 560 009.

Dr.G.V.Nagaraj MD., DPH.,PGDHM
I/c Director of Health and FW Services

Directorate of Health & FW Services
AnandaRao Circle, Bangalore-560009

DO.No.DHS/ 119 /2000-01

Dt.06-10-2000

To

Dear Doctor,

Sub:-Research into the modalities of application of principles of Health promotion in Karnataka State and integrating it with Health Education-reg

Karnatgka Chapter of the International Union for Health Promotion and Education , South East Asia Regional Bureau has been entrusted by the Health Task force, to assist in the conduct of the research required for realist and feasible recommendations to the Government .

In this connection, Dr.K.Basappa President, Karnataka chapter of SEARS, will be visiting your district to collect the required information and access all data of the district.

You are hereby directed to extend necessary co-operation in the above matter. I am requesting Dr.Basappa President Karnataka Chapter of SEARS to meet you in person.

With regards,

Yours Sincerely ,

To,
Dr..
District Health & FW Officer
Raichur,Belgaum,Kolar,Kodagu,Davangere,Hassan

Copy for kind information to
Dr.Basappa
President Karnataka Chapter of SEARS
590, 10th Main 5th Block,
Jayanagar, Bangalore-560 041

Copy to all the Programme Officers of this Directorate for needful action.

Questionnaire for Programme Directors and Specialists

NOTE: Please Mark: Strongly Agree - SA: Agree –A:
Agree with Reservation –AR
Do not Agree –DA.

1. Health Education is very important for successfully implementing any Public Health programme ...
2. Health Education Programme to be effective it must have been well planned and relevant to the Health Programme to be implemented ...
3. All health programme have inbuilt Health Education component ...
4. In order to obtain maximum cooperation from the people, the Health Education activities must reach all people in the community ...
5. Many health programme do not succeed, because people do not participate fully, with programme implementers ...
6. Because of illiteracy and traditional bent of mind, people do not take interest and learn about health ...
7. It is very difficult to educate our people on health, because many of them are superstitions and indifferent and do not believe in what Health Worker say. ...
8. Peoples participation in health programme means: ...
   a. Obtaining the benefits only ...
   b. Taking part in planning and organization ...
   c. Taking over the control of implementing and evaluating the programme ...
   d. As of the above. ...
9. Health education programmes must be directed only for those who are in need of it. ...
10. Health education programmes should be directed for all people in the community. ...
11. Health Education is an activity that all Health Workers should be entrusted with this responsibility. ...
12. All Health Workers should do health education work on all health issues at the grass-root level and it should be continuous and regular ...

13. All grass root level Health Workers should be given training in elements of health education techniques and periodically their skills and knowledge should be updated. ...

14. To organize health education programmes for the community and groups, there must be one Health Educator in every PHC/every taluk, who has DHE qualification ...

15. Block/Taluk level Health Educators should organize, plan and implement health education programmes regularly with the assistance of grass root level workers. ...

16. Regular health education programmes should include all health programmes of the PHC and not only Family Welfare programmes. ...

17. These health education programmes should be implemented with the active participation of people in the area. ...

18. It is the responsibility of the Health Educator to ensure people participation like, local Women's Swasthya Sangh, Village Health Committee, Womens self help groups etc. ...

19. Money and material resource required for these health education programmes should be raised locally from local philanthropic people. This should be the responsibility of Block level Health Educators with the help of local Medical Officers and local Village Health Committee. ...

20. Block level Health Educators should not be given any other responsibility at the PHC level other than Health Education and Communication. ...

21. Medical Officers of Health and Taluks Health Officers should monitor and evaluate monthly and report to the District Health Officers. ...

22. Health Educators should be effective communicators and have the knowledge and skill to speak and write on health issues in local dialects of Kannada. ...

23. Health Educators must be able to synthesize information on different topics and issues and apply interpersonal skills like, negotiations, lobbying and demonstrate the leadership skill. ...

24. Health Educator must be able to build allience with other professionals and organizations and collaborate with them to implement health education programmes. ...

25. He must be able to assess the health need and determine priorities for health promotion activity. ...

26. He must be able to develop and select suitable strategies for health promotion. ...

27. There is need for one District Health Education Officer who should supervise and guide the Block Level Health Educators. ...

28. The District Health Education Officer should be from among the Block Level Health Educators with Master Degree in Social Science and DHE qualifications. ...

29. The District Health Education Officer should undertake Advocacy programmes for district level policy makers and technical programme officers of other Departments. ...

30. The District Health Education Officer should assist the District Health and Family Welfare Officer in planning, implementing and monitoring district health education programmes. ...

31. The District Health Education Officer should be able to convince District Health and Family Welfare Officer and through him the Zilla Panchayat President and the Chief Executive Officer for better treatment of health programmes in terms of implementation and allocation of resources. ...

32. The District Health Education Officer should be able to plan, organize and monitor regular and special health education programmes of the district. ...

33. The District Health Education Officer must be able to study the district development plants and identify the health components in them and bring it to the notice of the District Health & Family Welfare Officer. ...

34. The District Health Education Officer should be incharge of film unit which is equipped with transport. ...

35. The District Health Education Officer must be able to produce IEC materials depending upon the local requirement. ...

36. The District Health Education Officer should be answerable to District Health and Family Welfare Officer and the Programme Director at the State level. ...

37. Health Education Programmes should be monitored by the programme officers at the State level regularly to infuse enthusiasm and discipline. ...

38. Health Education programmes should also be planned for the State by the Planning Cell at the Directorate. ...

39. The State Planning Unit should include all the programme Directors and the plans should be comprehensive and include all relevant health issues. ...

40. Health Promotional strategies like, Advocacy, Social Support and Empowerment must be undertaken by the District Health Education Officer at the district level and programme Director at the State level. ...

41. The Programme Director at the State level should be provided sufficient trained and qualified staff to plan and monitor health promotional strategies on continuing basis. ...

42. Programme Director should report regularly the working of his Unit to the Director of Health Services. ...

43. Programme Director should have direct control over the DHEO. ...

44. The IEC production unit should also be under the control and direction of the Programme Director. ...

45. The existing District Health and Education Officers should be trained in the health promotional strategies and programmes and communication and skill development. ...

46. Training of District Health Education Officer should include epiemiology of health issues; ability to analyse the behavioral, political and environmental influences on health, intersectoral coordination, interprete and report evaluation programmes etc. ...

47. Any other suggestions are welcome. ...

List of documents to be obtained from the Directorate of Health and Family Welfare Services

1. Statement of Health Education Policy.

2. List of Health Education Staff

	Sanctioned	Working
At the state level		
At the district level		
At the PHC level		

3. Administrative chart of the health education wing.

4. Job responsibility of various staff mentioned in item 2.

5. List IEC activities, planned and achieved in the last 3 years.

6. List IEC activities subject wise if available.

7. List of subjects covered in health education.

8. Health education action plans at the state level for the last 3 years and achievements.

9. Budget allocation for health education for the last 3 years.

10. Feed back statistics in the performance of health education work as a whole for the last 3 years.

11. Administrative circulars and guidelines issued from the Directorate for the last 3 years.

12. The list of Health Educators with D.H.E qualification and without D.H.E. qualification.

13. List of IEC material produced in the last 3 years and the amount spent.

14. Any other information related to function of the Health Education Wing.

List of documents to be obtained from the District Health and Family Welfare offices from each district

1. List of staff of Health Education Wing – DHEOs and HE s .

	Sanctioned	Working	No. of working months
1998			
1999			
2000			

2. List of people with and without DHE qualification.
3. District action plans and achievements for the last 3 years.
4. List of Health Educators undergone inservice training for the last 3 years.
5. List of subjects covered in health education activities.
6. List of charts and diagrams, posters etc., prepared / received to the district.
7. Activities of District Health Education Officer.
8. List of IEC activities planned and achieved for the last 3 years.
9. Budget allocated for the IEC activities and the amount spent.
10. List of statement of performance of the health wing for the last 3 years.
11. Any other activities related to health education.

HEALTH EDUCATION PRACTITIONERS
HEALTH EDUCATORS DHEO/BLHE

Remarks – 1. Strongly Agree (SA) 2. Agree (A) 3. Agree with Reservation (AR)
4. Do not agree (DA) 5. Not Done (ND)

1. Usually Health Education programmes should be planned at the State level every year and evaluated against the objectives.
2. When planned, it should be preferably jointly done with all other divisions of the Directorate, like RCH, Communicable Diseases, AIDS etc.,
3. If there is no comprehensive plan of health education as suggested above, how it is done at present. Tick the appropriate ones.

   i. It is the concern of the individual division
   ii. Health education experts are not consulted
   iii. Usually health education experts are included in the panel
   iv. Health education programmes are conducted as per guide lines given by the Central Health Education Bureau for the individual divisions.

4. In the preparation of the health education programme which of the following are considered at the State level.
   1. Literacy level in the State.
   2. Proportion of SC & ST in the population.
   3. General misconceptions, level of awareness about the subject.
   4. People's attitude.
   5. None of them are considered
   6. All of the above should be considered
5. Health education programmes should be directed.
   1. towards all people and also
   2. directed towards specific groups like women - old-age - children and also against specific diseases like Malaria, Leprosy, Tuberculosis etc.
6. Health education is usually targeted to individual persons, groups and general public. In your opinion which one you target most and least.
   1. Most
   2. Least
7. To change the behavior of people, series of orderly steps are required. Awareness, interest, motivation trial and adoption. Do you follow these principles in organizing health education programmes.
   1. Yes
   2. No
8. How strongly you agree with the practicality of these principles
9. Following methods are used for health education:
   (a) Talks (b) Group discussion (c) Seminars which one of these you have used most and which least.
   1. Talks (person to person)
   2. Group discussion
   3. Seminars
10. Visual media is said to be better. Which of the following media you are in your daily work. (1) Flipchart (2) Flanel graph (3) Posters (4) Wall paintings
11. How often you use mass media for health education for awareness creation.

	Often	Very Often	Rarely
Jathas			
Film shows			
Dramas			

T.V. shows
Street plays
Health education activities
Organisation
Meetings
Supervision
Health talks
Others

12. In a week, how many days you are engaged in health education activities

13. Have you formed Health Committee in villages? Who are the Members? How is their influence – (Great – Not much – Useless)

    How often the Committee Meet?
    Once a month / 3 months / Not regularly

14. Do you know influential leaders in your area? What is their contribution? Give their names if you remember.

15. Influence of opinion leaders of the local area is very important in motivating people. How do you rate the influence of the following people. — Yes / No

    Informal leaders — Give ranking 1 2 3 4
    Panchayat members
    Religious leaders
    Caste leaders
    People in the neighbourhood
    Family members

16. Among the family members, how do you rate the influence of these: — Give ranking 1 2 3 4

    Mother
    Father
    Mother-in-law
    Father-in-law
    Brother
    Sister

17. Rank the role of the following local organisations in creating social pressure on people to change their behaviour. — Give ranking 1 2 3 4

    1. Village Health Committee.
    2. Self Help Groups.
    3. Mahila & Youth Mandals.

18. Health promotion activities goes beyond Health Sector and extends for the following other government sectors. Do you use them in your activities.? — Yes / No

    a) Engineering Sectors — eg: Watery Supply
    b) Agriculture & Harticultural Sector — eg: Growing fruits and vegetables
    c) Community Development Sector — eg: Income generation, child care, nutrition.

SUPERVISORY LEVEL – STAFF

Senior Male Health Assistant — Lady Health Visitor
Block Level Health Educator — District Level

1. Experience	"
2. Awareness of job responsibilities	"
3. Is health education one of their job	"
4. Attitude: General activities	"
towards health education activities	"
5. Knowledge about supervision	"
Guidance	"
6. Improvements of the above	"
7. Areas of supervision/guidance	"
8. Programme planning – is health education included	"
9. Improvement of planning	"
assessment	"
10. Social mobilization	"
Knowledge	"
Opinion	"
Methods	"
Skill in talking to people	"
Ability in mobilizing public opinion	"
11. Role of V.H.C. Panchayat	"
S.H.C. Mahila Mandals	"
Religious Leaders	"
12. Inter-Sectoral Coordination:	"
C.D.P.O.	"
Revenue	"
Engineering	"
Harticulture	"
Agriculture	"
13. How often you meet	"
Can this work	"
Can this be useful to you	"

GRASS ROOT LEVEL WORKERS

Ranking: Highest to Lowest

A	B	C	D

1.	Experience		
2.	Awareness of job responsibility.		
3.	Health education as one of the job.		
4.	Attitude General Technical – all fields Health education fields		
5.	Knowledge in the fields: General Health education.		
6.	Areas of his/her concentration in health education		R.H. F.P. C.D. P.H. E.S. Nutrition
7.	Level of Knowledge		R.H. F.P. C.D. P.H. E.S. Nutrition
8.	Use of Health Education methods Knowledge Use/Practice		
9.	Social mobilization activities Skill in talking to people Knowledge about the local people & their influence on people What are the methods: Jathas Dramas Folk songs Film & Video Films		
10.	What is the role of Village Health Committee & Panchayat. SHG, Mahila Mandals		
11.	Advocacy – Generate public demand Peoples participation Helps in social support		
12.	Inter-Sectoral-Coordination: C.D.P.O Revenue Engineering Harticulture Agriculture In what way they can help you and health programmes - in your view how can you help them in their programmes.		

PUBLIC HELATH ENGINEERING DEPARTMENT

(Chief Engineers, Superintending Engineers/Executive Engineers of the Public Health Engineering Department)

Remarks : Strongly Agree (SA), Agree(A), Agree with Reservation (AR) Do not Agree (DA)

1. Introduction of IUHPE- outline of the Research Project. :

2. Public Health Engineering works in the long run results in improved community health. :

3. Engineering projects have health impact both directly and indirectly, for example, Big Dams, Hydro-Electric Projects, Roads etc., have positive impact on health of the people indirectly, whereas drinking water supply and sanitation have direct impact on health. :

4. Engineering projects can also cause ecological imbalance and affect the health of the people adversely. :

5. Engineering projects can also create health hazards to people in the vicinity of the Project by creating water stagnation which help to breed mosquitoes :

6. Many irrigation channels that run closely to the villages can create dampness in the residential houses and thus have bad effects on health. :

7. The above (5-6) illeffects on heath are preventable if proper preventive measures are taken at the time of construction. :

8. In addition, there is need to use the principles of public health engineering in town planning and village planning. :

9. There is a need to consult or avail the public health advise both in the planning and implementation stage in public works. :

10. Are there any consultation between public health and public health engineering departments in the State. :

11. How strongly you agree for the suggestion that the public health expertise should be sought where health of the people is involved either directly and indirectly. :

12. Have you had any orientation of health implications of engineering projects during your B.E. course. :

13. There is M.E.P.H. course in the Engineering College. Do BE graduates with MEPH are absorbed to public health engineering sector. :

14. Is there any need for inter-sectoral coordination with health or public in health Engineering sectctor :

15. Suppose there is strong plea from the public health expert for increased allocation of resources for projects that helps to improve public health or prevent illeffects on health, what will be your reaction ? :

16. If Health Expert is appointed to certify that every engineering projects have been completed without causing any harm to public health. What will be your reaction ? :

U Basavaraj

Karnataka Chapter

Bangalore