"KARNATAKA MARCHES TOWARDS HEALTH PROMOTION IN 21ST CENTURY"

FOCUS
ON HEALTH
PROMOTION

DRAFT FINAL REPORT
JANUARY 2001

INTERNATIONAL UNION FOR HEALTH PROMOTION AND EDUCATION

SOUTH EAST ASIA REGIONAL BUREAU

KARNATAKA CHAPTER.

Why have 2 divisions of the Health Education Bureau
Why so many vacancies?
What has been the outcome?

Collaboration with other sectors
- Education
- Information and broadcasting
- Agriculture
- Industry

Funds allocation
utilisation. barriers to utilisation

Restructuring the staff at various levels
Districts
Talukas
PHCs.

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KARNATAKA CHAPTER.

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PREFACE

Health promotion is defined as 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 of 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 Services. A rapid assessment of the State of art of 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 Health 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 Centres 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 organizations 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.

PRESIDENT
IUHE/SEARB - Karnataka Chapter
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Ananda Rao Circle, Bangalore-560 009

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SECTION - I

A. INTRODUCTION
B. OBJECTIVES
C. METHODS & MATERIALS

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 developmental 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 group 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 included 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 Districts who are looking after planning and implementation of health programmes in their district. These information have been tabulated and analysed.

3. Data was 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 districts 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 to 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 and feels worthwhile to do health promotion work.		
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 STATEMENTS		
	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 Services	1	1
2.	Additional Directors of Health & FW Services	4	3
3.	Joint Directors of Health and 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 Supervisers, 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 CHALLENCES

But the evidence available is quite the contrary. Mckeown's research has shown that past improvement in health has been due mainly to modification of behaviour and changes in the environment. For example, Mckeown'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 Governments 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 (13) Rehabilitation services. These are the direct causes. The indirect causes 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 health care providers, equity and social justice etc.

In these circumstances peoples 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 peoples 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 establishments.

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 live under conditions where healthy life styles are feasible. It means that they have the power to make healthy decisions – 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 as 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 get 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 determine 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 interests 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 policy 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 supportive 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 minimum health infrastructure and it should be easily accessible, he/she 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 generates 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 behavior. It may be about small family norm, giving up tobacco and alcohol, extramarital sex or age at marriage etc.

These health promotion activities helps 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 environment and public health and between the developing and developed 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 plays 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 own 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 professionals need to embrace an 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 sectors 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 of 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. Fostering 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 own 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 to 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

7. 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.
8. There are differences 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.
9. 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.
10. 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.
11. Those who plan health educational programmes must be capable of adopting educational strategies for various sub populations of that community on the basis of characteristics that may be practically identified, such as age, sex, neighbourhood, ethnic and cultural identity.
12. 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 governments and non-government organizations, religious leaders, traders, industrialists, politicians and all those concerned with governance of the country 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, favourable 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 favour 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 Mandals, 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 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 Organizations
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 standard, 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 mission, 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 in 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 mortality due to gastro-intestinal disease come down markedly during the same period. 60 to 70% of these improvements are attributable to safe water supply 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 still experiencing the very 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 diseases and social costs.

The evidence that health promotional policies and actions yield substantial health benefits is being accumulating. The experience of the western countries who have implemented and are implementing health promotional programmes in their communities have shown substantial improvements in health of the population besides bringing down the burden of diseases and social costs.

B. Benefits from behaviour modifications

1. School Health

School health programmes in 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 indicate that greatest effectiveness lies when programmes are comprehensive and "holistic" linking the school with health services, and where adequate attention is given for teachers training. Health promotion in schools has emerged very strongly in the last decade in Europe and is spreading to the whole world as a mechanism to combine a variety of elements achieving maximum health outcomes.

2. Cardiovascular diseases (CVD) and Cancer.

There is clear cut evidence that cardiovascular diseases come down significantly when health promotional activities like campaign against smoking change in dietary habits, encouraging physical exercise are implemented. For example in Finland, cardiovascular mortality has reduced by 73% since 1772 and all cause mortality has been reduced by 50% in working age of population over the same period. In a similar way, North Caroline experienced 71% reduction in lung cancer mortality and 44% from all other cancers.

Other studies show that programmes aimed at changing lifestyle habits bring very positive health benefits. For example, WHO collaborative study in Belgium for CVD prevention resulted in 25% reduction in CVD mortality. Programmes aimed at lowering serum cholesterol through healthy diet produced an average reduction of 15% serum levels of cholesterol among school children. One percent reduction in serum cholesterol act ion through dietary knowledge would bring a 2 to 3% reduction in coronary heart diseases. This was evident in Nevertheless campaign launched by super markets.

3. Reduction of smoking benefits

The World Bank estimates that economic burden from smoking including health costs and loss of productive capacity by disability or death is around 200 billion annually. 50% of all smokers loøse 20 years of life expectancy. Besides smokers pollute the atmosphere in their homes and public places. Smoking habits can be brought down by variety of health promotional measures like pricing cigarettes and legislation. There is evidence that 10% increase in the price of cigarettes (through taxation) leads on average to a 5% decrease in the quantity smoked and

the decrease in 15% among young people. Legislation restricting smoking in working sites in Finland led 2.4% smokers quitting smoking and 14.3% reducing the quantity consumed.

Further, smoking cessation programme in schools have resulted in 30 to 50% fewer smokers, especially in peer groups. However, there is also evidence to show that without follow up with multiple strands of action, these rates do not hold. Smoking cessation programmes over a 20 year period have yielded 13% less 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 be most cost effective programme. The cost per life year gained from such programmes ranged from 2000 to 5700, whereas 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.

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 brain damage.

5. Healthy Ageing

The real key to healthy ageing is to begin health promotional 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 keepin 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 in 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 shown to have profound effect on health 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 increased 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. Stalwarts 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 then 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, organizing and conducing of seminars conferences, family group teaching etc.

6. Fostering cordial intra and inter-departmental coordination and building good 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.	Category	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 Health Education Officers	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 qualification 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 Centers. 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.

? ? ? ? How should it be reorganised

Why do we have the two directions ?
Does it help in getting funds from GOI for RCH ?

STRUCTURE OF THE HEALTH EDUCATION BUREAU - II

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

Sl No.	Category	Sanctioned	Working
	Additional Director	1	1
	Joint Director	1	(vacant)
	Training Unit		
	1. Training Officer	1	1
	2. Health Superviser	1	1
	Student Health Education Unit		
	1. Deputy Director	1	1
	2. Assistant Director	1	v
	3. Dist. Nursing Officer	1	1
	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
	Field Study & Demonstration Unit		
	1. Technical Officer	1	v
	2. Health Superviser	1	v
	3. Public Health Nurse	1	1
	4. Home Science Assistant	1	1
	5. Social Scientist	1	1
	6. Teacher	1	1
	Exhibition Unit		
	1. Technical Officer	1	v

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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 Health Educator organise, the IEC activities involving grass root level workers and 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 undertakes 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.

Are the posts sanctioned according to GOI norms? What are the funds available/ utilized? Are funds lapsed?

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 and 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	-inl-	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 Daugher-in-law program	8545	6921	81
13.	Mahila Dinacharini	6320	5073	80
14.	MSS Workshops: Taluka Districts	175 9	160 9	90 100
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.	1999-2000	61.48 lakhs

E. 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 Officers 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 in 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 briming down birth rate and increasing the couple protection rate (58.6%) cannot be attributed soleley 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 bring 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 units have a definite function to perform.

For example (l) 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 for 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.

? What do the people available do

(2) Functions of Field Study and Demonstration unit are (a) Main purpose of this unit is to find out most suitable, effective 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 technically and scientifically. This unit also is not functioning because of the absence of the key staff for a very long time. The existing staff do carryout some work 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 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 1986, 122 Primary Health Centres 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. Healthfull 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 supervises 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 Worke 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 immunisation services given to I, 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.	Teachers 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 and 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 in 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	...	83.8%
	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 immunizations service is monitored at the State level. The performance of each district is scrutinised and progress noted. The districts 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 our 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. The Education Department is not sufficiently collaborating with the health staff.

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 at 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. R

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. R

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 on a phased manner. R

Teachers 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. R

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 evencing sufficient interest in the programme. District Health and Family Welfare Officers must start advocacy programme for District Education Officers and Zilla Panachayat 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 discussions on the performance of school health activities. R

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

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. R

Question of bringing 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 Health Education Bureau and special health education campaign should be left to the respective programme Directors.

Recommendations on repositioning of Health Educators.

One BLE post may be sanctioned for every PHC in the State in a phased manner at the rate of at least 200 posts every year for the next 5 years.

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

The District level health educational staff at the rate of one DHEO and two DDHEOs per district may be retained and the excess staff may be posted to taluka health office.

Taluka level health offices which are newly created should be provided with Deputy Health Education Officers at the rate of 1 DHEO per taluk. This will strengthen the taluka level health organization and he will have sufficient population strength and monitory resources to plan and carryout IEC activities. All the taluka level Health Educators should be assisted to own two wheelers and the fuel charges may be sanctioned. This will help him to tour the area and implement the new strategies under health promotion.

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 Supervisers.
3. Health Educators.
4. Interaction with other Health Related Departments.
5. Interaction with Non-Governmental Organisations.
6. Interaction with People.

1. GRASS ROOT LEVEL WORKERS

Total of 50 workers from 4 Districts posted to 16 Primary Health Centres 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 responsibilities (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 mobilisation techniqus. However, they are not making any effort to get the cooperation of the Village Health Committee members 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 them expressed they must have frequent meetings involving mother-in-laws and daughter-in-laws and other elders, where they can discuss common health problems and remove some doubts and misunderstandings, 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 methods	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 prog5ramme is satisfactory. However, they are not in a position to appreciate and involve the local people in either planning or implementing the health programme in the villages. Though they understand the need and advantages 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 programmes. People participation 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 realised 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 programme 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 meetings and conduct them as planned at least once per week so that they can hold at least one 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.

Health Supervisers

A total of 28 Health supervisers 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 in 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 sows and baby shows.

In many places, Health Supervisors and resource persons 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 lead 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 - 4

Health Supervisers, 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, health education programmes, there seems 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 organised 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 to be 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 District Health Education Officers and 4 Deputy District Health Education Officers working at District level were interviewed and participated in focus group discussions.

Competency

As shown in table 6 most of them are 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 a neglected lot. There contribution is not recognised 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 doubtfull. 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 programmes. In fact, part of the reason for tardy progress of health education programmes is attributable to non-involvement and half hearted participation of the people. This is the case in all health programmes. It may be improper Malaria Eradication, Poor Tuberculosis Control low couple protection rate etc. Therefore, training and re-training of the Health Educators in social mobalisation 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 form the Districts.

Short term

Immediately, there is great need to arrange training programme for all the Health Educators on health promotion. A programme of reorientation for District Health Education Officers and the Deputy District Health Education Officers and those possessing DHE qualification may be organised 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 weeks training programme may be organised 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 mobilisation. They should also be trained in modern electronic media and utilization of computers.

Table - 6

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

		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 about 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	60	30	10
	practice of social support	20	30	50
14.	Knowledge about empowerment	40	30	30
	practice of empowerment measures	20	40	40

MEDICAL OFFICERS OF HEALTH

Twelve Medical Offices 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. However, not all of them are indifferent towards health activities. Those who do not have much clinical practice do well in all health programmes 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 Offices who have good clinical practice take the help of health workers to assist him. Doing clinical work is good for the people, because many patients 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 administration and management of health programmes has been a failure. Now Taluka Health officers have been established and Taluka Health Officers must be made Administrator of Health Services 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 ANLYSIS IS AS FOLLOWS:

	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 MAKE PART, IN PLANNING PROGRAMMES
3.	IMPROTANCE 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.	NED FOR FURTHER TRAINING OF HEALTH STAFF	ALL AGREED THAT HEALTH WORKERS SHOULD BE TRAINED AND NOT THEMSELVES.
6.	QUALIFICATION REQUIRED FOR HEALTH EDUCATERS	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 WORKER IS NOT APPRECIATED BY MANY DOCTORS AND MUCH LESS THE ADMINISTRATORS. IT IS RARELY THAT GOOD HEALTH WORKER (DOCTOR) IS APPRECIATED, WHERE AS GOOD CLINICIAN IS APPRECIATED BY ADMINISTRATORS AND POLITICAL LEADERS, ALIKE

OPINIONS ON 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 favourable 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 is 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

	STATEMENTS RELATED TO	AGREED OR NOT (PERCENTAGE)		
		STRONGLY	AGREED	DISAGREED
1.	THE NEED FOR HEALTH PROMOTIONAL STRATEGIES AND THE RATIONALE AND POSSIBILITIES OF IMPLEMENTATION IN DEVELOPING COUNTRIES	20	80	-NIL-
2.	METHODS OF PLANNING AND IMPLEMENTATION	10	90	-NIL-
3.	IMPORTANCE OF SOCIAL MOBILISATION.	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

	STATEMENTS	PERCENTAGES AGREED	DISAGREED
1.	THE CONCEPT, PRACTICE AND IMPORTANCE GIVEN FOR PUBLIC HEALTH BY HIGHEST DECISION MAKING PEOPLE ARE IMOPORTANT 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 IMPLEMENTATION LEVEL.	98%	2
3.	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.	70%	30%
4.	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 LITLE 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 PROFESIONAL SHOULD MEET REGULARLY TO REVIEW THE HEALTH PROBLEMS AND RESEARCH 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 PRORAMMES (THIS INCLUDES HEALTH) ARE OPERATING UNDER EVER TIGHTER RESOURCE CONSTRAINTS. THEREFORE, THE CONTRIBUTION OF GOOD HEALTH TO SOCIO-ECONOMIC DEVELOPMENT MUST BE CONVICINGLY 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 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.	100%	-NIL-

4. Inter Action with other Health Related Departments

Findings

Intersectoral coordination of all developmental 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 Department and their Departments but expect that the health department to take initiative 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 programmes can be implemented smoothly and quickly. Moreover, the proper and successful implementation of health programmes would also help other non health related programme substantially, because people take more and keen interest if the programme is health related. Therefore, there is need for organising advocacy programmes for managers and policy makers of other developmental 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 instead strengthen interposal and Interdepartmental bonds and helps cohesion and purpose in government institutions. This is very important because people are loosing confidence in government run programmes.

5. Iteraction with Non-Governmental Organisations

Eight non-government organizations in 4 Districts implementing some health education activities were contracted. 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 be better than government organisation but the budget of NGOs is very high compared to government organization.

In the long run it may be better to involve more and more NGOs in health related work and a mechanism has to be found to identify real social service minded NGOs and try to encourage them. Unless socially spirited people come forward to manage non-government organisations 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, careful verification of non-government organisations and the staff composition and the background of people who run such organisations is required before entrusting any health related projects to them.

6. Interaction with the People

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

Findings

Most of the respondents showed indifference to our questions. On probing further, they revealed 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/HIV.

Many villagers 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 for male sterilisation.

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 interested to have toilet facilities in their homes.

Recommendations

Therefore, there is need to launch health education programme (advocacy) 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 and 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 diseases and disability still persist as public health problems. This is due to partly, to administrative and technical problems in the control of infectious and nutritional diseases and partly 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 chronic diagnostic facilities, costly drugs and longer hospital stay. Relatively, more health budget is being spent on elderly people than young and middleaged 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, is recent years in the incidence of malaria, tuberculosis and HIV/AIDS.

Therefore, there is clear indication that the present and past public health policies and strategies are not sufficient to lessen the burden of disease and disability in the state in has lead the state 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 consider all the above, factors has suggested to all countries apply the principles of Health Promotion in their health policy. The Karnataka State would do well to implement these strategies to achieve 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.

The 5 strategies suggested by the Charter are:

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

Major areas of concern which should be adequately addressed are:

- Development of human Resources.
- Sustained action to build supportive environment for all people.
- Fostering intersectoral action for health.
- Forging partnership between non-government organism 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 productive lives at least by 2015 in the 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 weak 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 health promotional activities at the State, District, Taluka and Primary Health Centre level is adequate and no additions or modifications are required. The name of the State Health Education Bureau may be renamed as Health Promotion and Education Bureau. All the Health Education staff may be brought under one head.

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 disfunctining 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 effectiveness. Like wise 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 are no Health Educators post are sanctioned at present. Therefore, one Health Educator post may be sanctioned for every taluka. The State has sufficient number of Health Educators 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 Officers 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 moulded 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 to issue guidelines and modify the syllabus in Community Medicine for both at undergraduate, diploma and degree courses.

D. 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 should 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 the 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) teaches training (3) providing good clean and well ventilated class room (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 I 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 practice by the individual, family and community and 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.

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

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 undoubtedly a type of intervention, functioning type of the person, type of life style, attitudes, 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 ~~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.

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 worthwhile. 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 makers, 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 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 research. 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 research is cheaper and more usefull because it gives feed back to the health programme manager to change the directions if 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.

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 devidend 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 attracting root causes of diseases than trenting 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.

Intersectoral Coordination

It is very clear and apparent from 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 becomes very necessary and crucial for successfully implementation of health promotional activities. Many case studies and opinion of experts show that comprehensive multi-disciplinery health promotional programme yield better results than solo sector.

The study reveals that there is no strong linkage between health sector and other development sectors both at the top and 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 comprise$ many health promotional components are:

- 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 liason 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 (SHP). 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.

2. Information & Broadcasting Department

This sector is very much relevant to day than ever before. Because of the explosing of information on health promotion an multitude of media telecasting such information. Many TV Stations in their enthusiasm to make T.V. shows attractive especially by 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 this negative telecasts 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 liason with the Health Sector.

3. Collaboration with Non-Government Organisations

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 usefull 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.

OTHER RECOMMENDATIONS

1. Recommend to the government to give directions and support to the Health Sector and other development departments in line with the recommendations in W.H.O. 9th general programme of work.

2. Request the government to include public health experts in the top policy making bodies.

3. Request government resource allocators to take long term view of benefits of Health Promotion & Education before deciding the financial allocating to various ministries.

4. Request the government and non government organization to look into the question of equity and social justice in providing health care services.

5. Request the government and philonthropic organizations and non governmental organizations to support provision of Water Supply and Toilet facilities to all villages and towns.

6. Request the government to issue guide lines to Education and Health departments to take up comprehensive. School Health Education and Promotion activities and allocate required financial and other resources.

7. Request the government to take urgent steps to prepare a model for communication strategy for Health and Innovative Methods and approaches to effective communications.

8. Appeal to the public to participate in Health Promotion & Education activities to gain control over the determinants of illhealth.

9. Request the government to reverse its decision on qualification required for administrative posts at District and higher levels. All higher administrative posts in the health department should be filled up with public health qualified people only.

10. Policy Makers in Public Health and health Professional Should meet regularly to review the Health Problems and Research Evidence available for their decision making.

11. 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 sector.

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

13. 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.

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