EDUCATE ALL PEOPLE ON HEALTH ACTIVITIES

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Scheme aimed at obtaining complete understanding and unstinted cooperation from all sections of the community to maximize health service utilization and to derive all possible benefits from the ongoing programmes with full participation and involvement of the communities.

Introduction

It has been observed that due to the prevailing attitude of the people, health programmes aimed towards alleviation of diseases, disability and death and to build up a nation more healthy and productive suffer greatly, and the aims of the programmes and health activities remain unfulfilled. The general education being poor, (literacy rate 13.9%) and traditional customs and practices being deeply rooted in the behaviour of the population, it has been found that the task of obtaining complete understanding from the population at large and their unstinted cooperation, whether they be public officials or private entrepreneurs, social community workers or teachers; educated or illiterate, urban or rural; and from every walks of life; has remained one of the unsurmountable tasks for the health organisers in the country.

Many of the unnecessary and preventable diseases, disabilities and deaths could be reduced to a great extent if a proper practicable and inexpensive way could be found to

educate people at all levels of all sections, and the entire community as a whole so that planned changes in behaviour could be achieved in a gradual but sure way.

It is desired to discuss the problems currently faced by the community and difficulties the organisers face in implementing health care programmes to offer maximum benefits and possible approach towards obtaining understanding from the total population.

PART I

NEPAL:

Geography:

Nepal is a tiny mountainous rectangular country 90 to 150 miles broad and about 500 miles long and has approximately 142,000 square kilometers total area. Almost all its boundry bordering the Tibetan Region of the peoples Republic of China constitutes nerely one third of the Himalayan bastion upon which the Indian subcontinent has long relied for protection. Landlocked and sandwiched between the two - populous giants of Asia. Nepal's positions is quite interesting from a poltical point of view. It is bounded by Sikkim, Indian protectorate in the east, India on the south and west and by Tibetan Region of China on the north. Kathmandu the capital city is centrally situated and is about 500 miles east of New Delhi and approximately 1900 miles from Peking (Peiping).

The rugged mountainous terrain forms about 67% of the total land area with massive Himalayan ranges stretching from east to west in the northern half of the country. The TERAI which has a belt of forest and plains separates Nepal from India on the south and consists of about 32% of the land area. The remaining 1% of the land area is covered by valleys.

Three separate river systems each having its head waters on the Tibetan plateau drain almost all of Nepal. These major river systems with their numerous tributaries, with their deep gorges and rugged transverse ridges are great hindrances for the development of easy communications. Travel inside the country is extremely difficult hazardous and time consuming. There are approximately 1499 kilometers of metalled, 360 km gravelled road and 1421 km Kacha Road which are usable in fair wheather, Nepal still has the lowest milage of roads in relation to its surface area in the world.

Within the 150 miles space from north to south are approximated most of the climatic zones of the world. All types of climates from Arctic Tundras to the Subtropical are encountered in this small country. Annual rainfall is about 2500 mm from June to September during which period travel inside the country becomes more difficult. A person wishing to travel from east to west has to enter India and to travel through India and enter Nepal at the point where he wishes to go.

and Vegetations;

The soils are diverse in composition and distribution and have in general a high pH text and a deficiency in humus, nitrogen and phosphates.

Deposits of various minerals among them coal, cobalt, copper, gold, iron, limestone, marble, and mica have been found. No systematic geological surveys have been carried out so far.

Forests cover more than a third of the country's total area. Nepal has a wide variety of wild animal and bird life, and is one of the famous big game areas of the world.

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The ethnic and cultural characteristics of the Nepalese people are closely related to the geography. The population is as diverse as the terrain. To a large extent the people in the rural area tend to group ethnically according to the elevation, by types of culture as conditioned by the elevation.

The people in the mountain border originated from ancient Tibetan stock, whereas in the Terai extreme, the people inherit the culture and traditions of Indo-European people of the Gangetic plain. It can therefore be said that the dominant strains in the population are caucasoid and mongoloid with varying degrees of admixture in the Terai area.

The latest population estimate is approximately 12.2 million with an annual rate of growth of 2.07%. Almost 95% out of this are considered to be living in rural areas. Approximately two-thirds of the population live in the mountainous and hill region, and one-third live in the Terai region.

The density of population varies widely from area to area. The mountain highland has less than 10 persons per square kilometer and in the plain cultivated area up to 775 persons per square kilometer.

Movement:

Notwithstanding the terrain and the fact that travel in much of the country is over narrow and precipitous trails many Nepalese are on the move during the dry season. Traders, Porters, barterers, Pilgrims, labourers and mercenaries move continually. There are many who live in twin villages one in valley bottom during winter and the other at a higher altitude during late summer and fall for animal pastures and may be to avoid malaria infection.

Languages:

There are 15 major ethnic groups with their own languages and dialects. Nepali is the official language and is understood in all parts of the country.

Religion:

Hinduism is the main religion closely followed by Buddhism, and there is small percentage of Muslims and a few Christians and others.

Economic stratification:

Nepalese society, seen in the terms of difference in wealth and access to political power within the national framework, can be divided into a small ruling elite, an intermediate group of government functionaries, land holders and merchants, and a peasant (class) comprising the vast majority of the population.

Economy:

Nepal is a poor country. The country is economically undeveloped and its limited wealth is distributed unevenly. Private citizens or groups of citizens try to raise levels of health and welfare and to fill deficiencies in the public sector.

Floods, droughts, famine, land slides, earthquake and epidemics periodically strike localities and cause sufferings and loss of life.

The country is predominantly agrarian, and agriculture accounts for over 65% of GNP and over 60% export earning.

Food grain products constitute the major crops (Paddy, Wheat, Maize and Millet). Timber export is also an important earner, and tourism is gradually increasing and is the main source of hard currency. Gurkha mercenaries are also another source of foreign currency. Industrial sector accounts a meagre 0.65% of the GNP.

Manufactured goods and food articles account for 68% of Nepal's imports 99% of Nepal's trade is with India.

The per capita income is U.S.\$ 80.00 per year and this is very low. Many of the poor farmers earn only \$5.00 to \$ 10.00 cash per year because of small holdings of land.

Education:—

There are three levels of education primary, secondary and higher. Five year of primary and five years of secondary education lead to school leaving certificate examination (High School level). Higher education is controlled by the Tribhuvan University the only University in Nepal The medium of instruction is English. Two years for Intermediate and two more years of studies for Bachelor's Degree in Arts or Science are required. Master's Degree requires a further period of two years study.

There are 86 Campuses under the University. A total of over 60000 students are enrolled in Campuses in High School and in different faculties of the University (12 faculties). The literacy rate is only 13.9%.

Transport and Communications:

Transport in the country is limited and difficult. Less than 1500 kilometers of paved roads are available for quick vehicular traffic. Often during the monsoon even some of these paved roads are blocked by land slides Most of the areas in the terai use bullock carts, horses, buffaloes and elephants for transport. Some people use wooded KHATAULLS (Chair like wooden seats) carried by people on their shoulders. A number of air fields (fair weather) and STOL landing strips join the country from point. There are 4 all weather airports; Boeing, Twin Otter and AVRO-Jet aircraft and other are used by the Royal Nepal Airlines Corporation for Internal as well as international flights.

Communication;

Sending of private messages and official instructions, mails, and wireless messages are possible, but final receipt of these are uncertain. The process is slow, at times taking weeks, and the purpose of such action is rendered useless by the long delays in transmission. Channels of communications are governments newspapers, private newspapers, wireless offices etc.

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Most easy method of communication which is the prevailing means available in most part of the country is.

"Word of Mouth"

Communication is of paramount importance in the dissemination of information.

Even though mass communication media are little developed stories and reports travel far and fast. Information is passed on from one person to another moving out in ever-widening circles form the central point of origin. Traders, holymen, beggers, porters, postmen, nobies etc figure importantly in this process, taking gossip from village to village throughout the country side, and so do the farmers and their wives, who go to the bartering centrally located bazars known as HAAT.

The seasonal and continuous movement of the people is yet another medium for news and gossip to travel far and fast. However, as can be expected, information spread by word of mouth is subjected to individual interpretation and is more likely than not distorted, exaggerated or completely twisted in version and therefore not the most reliable means!

Memberships of Interational Organizations:

Nepal is member of the United Nations (1955) and also of the following International Agencies, with dates of entry:- FAO-1951, UNESCO-1952, WHO-1953, ECAF-1954 IBRD and IMF-1961. Nepal is a member of UPU, ICAO, IRC and IPPF. COLOMBO PLAN- 1952 ADB World Bank and receives help from IDRC (Canada) Nepal takes part in all international meetings and events. Nepal has participated in the BANGDUNG Conference in Indonesia (1955) and the late King Mahendra himself led the Nepalese delegation to the Belgrade Summit conference of non-aligned nations held from September 1 to 6, 1966 King Birendra led the Nepalese Delegation to the Algires Summit conference (1973)

Foreign Relations:

After centuries of a isolation Nepal has evolved a foreign policy which may be described as neutralism. Nepal has diplomatic missions in almost all developed nations and has foreign relations with a large number of countries (52)

Political divisions and the system of panchayat Democracy and Government Administration:

The country is divided into 14 administrative Zones (Anchals) and 75 districts.

Village panchayats form the base of three tier panchayat System, District Panchayat forming the middle level between the village and the National Panchayat. One village or a number of small villages with a total of 2,000 or more population forms a village assembly composed of all nationals of over 21 year from these assemblies a Village Panchayat (Executive) is elected. There are nearly 4,000 village panchayats in Nepal.

A town panchayat has over 10,000 population and an executive committee is elected along the lines of the village panchayat. There are 16 town panchayats at present.

A district Assembly has one member from each village panchayat and 1/3 of the members of town panchayat and the members elect a district panchayat of 11 members.

The zonal Assemblies consist of all members of district panchayat and elect members to the National Panchayat.

The National Panchayat has 125 members 90 of which are elected from 14 Zonal Assemblies, 16 are nominated by the King; and class-professional organization eg. Graduate Constituency (4) peasants (4) Youth (4) Women's organization (3) Labour (Workers) (2) and Ex-Military association (2) elect their members to the National Panchayat through a system of filtration. There are at present about 4000 village panchayat and 16 Town Panchayats.

Administration:

The government has 16 ministries each headed by permanent Secretary. Ministry of Health is one of the 16 ministries.

There is a Department of Health Services under the ministry which has the responsibility of providing health and medical care in the country. The Malaria Eradication Programme is directly under the Ministry of Health. Proposal to establish Zonal Offices in all the 14 Zones are being carried out, and 7 Zonal Offices have so far been established.

Below the Zonal Offices, the District Offices are yet to be established, and to function properly and are offices in name only.

The Government is engaged in experimentation of the best types of health care and it will be sometime before positive results are obtained and health care organized. Recently country Health Programming and long term Health Planning exercises have been carried out and the outcome is awaited eagerly. Integrated mobile Health care has been

accepted as the method of choice to cover the population.

"In the absence of an organized vital static system in the country and limited coverage of hospital statistic it is difficult to define the health problem".

It is generally accepted that most of the tropical endemic diseases are prevalent in Nepal (abstract from HMG Master Plan for Health 1970-1975).

From the above it can be seen that so far the planners have been grouping in the dark, and therefore the health care facilities to the people are few and far. For the the 95% rural population large number of which live in areas where transportation and communication facilities are very difficult and no modern medical cares is available, the locally practised type of health protection and care are the only means to keep healthy and fit. The large rural population depends upon Ayurvedic (Indigenous medicines) Quacks, Astrologers, -who forecast planetary influences and advise religious rituals for cure, JHANKRIS (Shaman) who drive away evil spirits and diseases and generally a variety of precaution is taken against dangers to health which include wear ng charms, avoidance of pregnancy, and apropititation of ghosts, evil spirits and the gods with sacrificial gifts.

The Health Problems can be described under the following headings:-

- 1) Problems associated with actual disease.
- 2) Problems associated with the socio-economic status.
- 3) Problems associated with the general administration.

PROBLEM ASSOCIATED WITH ACTUAL DISEASE:

Malaria

Approximately 6.5 million of people are exposed to malaria risk. Malaria Eradication Programme has reduced the incidence to a very great extent and large portion of the malarious area is in the consolidation phase at present. However, malaria transmission is perennial in certain areas even today and these are inhabited by the most backward people. Many technical, operational and administrative problems are appearing which are causing grave concern to the government and there is great danger of re-establishment of malaria transmission all over the country. Large number of malaria cases are being imported from India and this has cause grave set backs in the MEP.

Tuberculosis:

It rates second to malaria as the cause of mortality. In a poor country with

very low levels of living for the greater number of people, and the slow growth of the economy. TB is a problem of magnitude. A TB control project is in operation.

Leprosy:

Although dependable statistics are not available the disease seems to be associated with densely populated areas and small surveys in such areas has given the prevalence rate to be 10 per 1000. A Leprosy control project is also in operation.

Smallpox:

It has been an endemic disease for many years. The last major epidemic was in the capital (Kathmandu) in 1958. Epidemics seemed to occur every five years. Surveys have indicated 12% scarring and mortality was known to average 30%. A smallpox eradication programme is in operation and has covered large areas in the country. Presently smallpox programme is also facing importation of cases from outside the country and this has proved to be a great hazard to the work of Small Pox eradication. Typhoid, Cholera and Gastro-enteritis occur all over the country in endemic and epidemic form. Measles, Pertussis, Diphtheria occur frequently. Routine immunization is not available to most of the people.

Rabies:

Occurs frequently in many parts of the country but as yet immunization of canine rabies is rarely available. Anti-Rabies vaccines are also not available in almost all places except in one or two towns.

Venereal diseases:

Occur frequently but no statistics are available and as yet no attention has been given to these diseases.

Trachoma:

This disease is found to be prevalent all over the country, its incidence and prevalence is subject to conjecture.

Filaria:

Is also prevalent as indicated by many cases of elephantiasis but no statistics are available.

Parasitic disease:

Various parasitic diseases are prevalent because of easy and frequent contamination of environment from improper and indiscriminate faecal deposits and non-existent sewage system. Ascariasis, Hookworm, Trichuris, Entamoeba histolytica, H. Nana and Giardia Lamblia occur often. Bronchial asthma incidence is high. Various other diseases also occur, but there are no statistical data available.

Nutritional diseases:

Iodine deficiency goitre occurs in many parts of the country. Nutrition deficiencies are manifested in all parts of the country by low resistance to diseases. Vitamin deficiencies are found to occur in many parts.

Shortage of food develops in many parts of the country from time to time due to floods, droughts or marketing and transport difficulties. Arthropod borne disease and viral disease do occur as all types of vectors are found in surveys but data are not available. The incidence of poliomyelitis must have been high as indicated by many paralysed persons seen in the hills (Worth and Shah, Nepal Health Survey 1965-66). Infant Mortality: is high 15 /1000 or over.

Female diseases: Occur frequently because of poor anti-natal, poor management during child birth and inadequate post natal care.

Population problems: because of annual growth rate of 2.07 and disproportional increase in food production and general G.D.P. rapid increase in population poses serious problem.

Problems Associated with Socio-Economic conditions:**Environmental Sanitation:**

Sanitary latrines are not regular features of a house even in the cities. In most part of the country indiscriminate defecation and the use of night soil and animal manure as fertilisers is a normal procedure.

Therefore faecal borne diseases are quite frequent. "Sewage disposal is non-existent, except in a few small concrete sewers and some large covered drains which collect raw sewage from every limited parts of Kathmandu city, and discharge into the Bagmati river" (Report of Health and Health Administration in Nepal Page 71). In the rest of the whole country including Kathmandu city there is no sanitary disposal of sewage.

Free exchange of infection from environment therefore occurs in all parts of the country. Garbage and solid waste disposal system does not exist anywhere in the country.

Drinking Water Supply:

Piped water supply is limited so far to the people of a few towns only. A total of about 10,00,000 people receive piped water which is neither filtered properly nor chlorinated continuously. For the rest of the people covered or uncovered deep or shallow wells tube-wells, open artesian wells, near by river and stream water and at times water flooding through the paddy fields make up the drinking water supply.

House condition:

Housing condition are poor with improper or non-existent ventilation. The houses are crowded, in narrow lanes, and have no sewers or drains. Sunlight rarely gets in. Many persons live and sleep in small rooms. In the hilly regions a kitchen, a cattle/goat shed, a living cum store cum bed-room may all be one and the same.

ALCOHOLISM: is gradually increasing in all communities, more among the sophisticated elite, and Gurkha mercenaries and the Labourers.

Transport and Communications:

The transport and communication is poor and unreliable. Accidents are increasing and will be major health problem in the near future with the rapid increase in the number of Vehicular Traffic.

Education:

General education is poor and the impact of diseases and the need to safeguard health is not usually understood by most of the illiterates of the country.

General Economy:

A poor country with per capital income per year of \$ 80.00 is in a very unfortunate position. The health budget is inadequate as the health sector rarely gets any priority. Since there is practically no private medical care except a few mission hospitals which are expensive, and as the government provides free of cost, all medical care, the organization

and implementation of good medical care programme to cover the whole population is beyond the resources presently available to the government as only 4 or 4.5% of the total national budget is allocated to Health Sector for the past two decades.

Problems associated with General Administration Planning:

Health Planning had been neither adequate nor far seeing. No data on vital and health statistics are available. Man-power Planning had not received due consideration in time and there is extreme shortage of trained man power due to lack of long term planning. There are about 380 MD's (including dentists).

HEALTH MAN POWER AVAILABLE FIGURES FROM HEALTH STALL IN THE DEVELOPMENT EXHIBITION.

Category of Health Workers	No of health Personnel	Ratio Health personnel per population
Doctors	374	1:33,000
Dentists	8	1:1444498
Nurses	335	1:34,495
Assistant Nurse-Midwives	372	1:34,372
Health Assistants and Auxiliary health workers	620	1:18693
Laboratory Technicians	35	1:330, 171
Sanitarians	8	1:1444498
Health Educators	14	1:8,25,427
X-Ray Technicians	22	1:525272
Kabirajas (Indegenous	93	1:231120
Baidyas (Practitioner)	50	1:231120
Health Aides	972	1:17196

The above figures include all the catogories available but some of the personnel in various cadre are no longer in the service some have to left the country and others having left their jobs. This attritive staff should be kept in mind as a problem.

Taking general ratio of manpower and population does not give a pupils of the inequitable distribution as there is concentration at some places while there is severe lack

somewhere else.

As the manpower requirement could not be filled the plan remained academic only. The plan seems to be summararily drawn that the obvious impossibility of obtaining the manpower needed was completely ignored and the plan cannot be carried out as envisaged and desired.

General Administration:

The organizational structure in the Department of Health is changed frequently. The intermediate levels in the organization are not uniformly established. Basic infrastructure of health is nonexistent but recently the two pilot projects have shown promise and are now accepted methodology of health Care delivery in the country.

Recruitment:

Recruitment rules are tenuous and rigid and because the general education is poor, and due to lack of interest in health work large number of vacancies occur all the time as a result of low incentive and insecurity of tenure and future and the temporary nature of most of the "development" projects of Health.

Training facilities:

M.D. training is not possible as there is no medical school. RN's at the rate of 40 per year can be trained in the country but the drop out rate is almost about 5% or more at times.

AUXILIARY NURSE MIDWIVES

80 in total per year can be trained. Auxiliary Health Workers 100 per year can be trained and Laboratory Technician 12 per year can be trained.

The training facilities are grossly inadequate, considering the need of the country and no other category of Health Professionnai can be trained and many other types of workers are required eg. X-ray, Blood Bank, Physiotherapists, Dental assistants, Optometrists, Chiropractors etc. Recently Radiographers and Lab. Technicians have been trained in the country. Due to high rate of attrition, the Nursing care is inadequate besides the fact that every hospital is originally inadequately a staffed. There is no division for Nursing in the Department of Health and therefore Nursing services are developed according to concepts of a non-Nursing individual who makes all the decisions and the nursing officer in the unit simply carries on as instructed.

PART II

The detailed information on customs, culture, religion, ethnic composition, the geography, economy, education and health facilities available to the people of Nepal described in the previous pages give a fairly clearcut idea how very difficult it is to educate the people in matters relating to health and healthy living. The low levels of living, poor education, difficulties of transport and communication and the relative unavailability of any type of modern communication mass media all combine to make the task of reaching the mass a difficult proposition and time consuming.

On the one hand the task of health educator and health planners is to educate the general mass who have little or nominal education, while on the other hand, to get the unstinted cooperation and complete understanding of the more literate people, the community leaders, the teachers, government officials and even the health personnel of all categories is a problem of no less magnitude.

A scheme to supply more and more informations about health, healthy living and the current health programme will therefore have to be devised on the lines describes below.

A Health Education Programme planning must have the following component for proper steps in planning process.

- i) who is to be educated.
- ii) Collecting baseline informations necessary for planning programmes
- iii) Set forth objectives.
- iv) Define constraints and barriers.
- v) Appraise apparent and potential resources.
- vi) Select Methods.
- vii) Plan Educational Programmes.
- viii) Evaluate Progress by (built-in-evaluation system)

1) Who is to be educated.

The people of the whole country have to be educated. They consist of the general mass, that is, the Community Leaders, Village Headman, School Teachers, Priests and Pandits (religious men) Community development workers Traders, Voluntary agencies, postmen and the people.

The other groups which require to be educated are various levels of panchayat workers and professional organization eg. Women workers, Peasants, Youth and Ex-service man (Veterans) organization and the functionaries of various levels of the government administration.

In a country where word of mouth is more of a medium for reaching the people and as health education is a continuous process, the best way seems to be in trying to establish Man-to man link so that the continuity can be maintained. Each individual is a Health Educationist.

II) Collection of necessary information:

- a) Vital and social statistics of the disease or condition including age groups involved are not available therefore concentrated attention is needed.
- b) Geographic and Physical factors.
Geographic characteristics- and their attitudes, beliefs and practices, intrinsic and extrinsic characteristics of person, time place, and experiences.
- d) Health facilities available.
- e) Who do the people really believe, what media are there for dissemination of informations.
- f) Past experiences of the planners regarding the "acceptors" and rejectors" of social programmes and health programmes.
- g) Current health and social activities and programmes and the people's reaction to these. Is there a conflict between various social programmes or between one and other types of health program?
- h) Particular groups of population who need more attention than others.
- i) The relevant informations which may be necessary.
- j) Changes of social custom and occasions, emergent and routine.
- k) Informations about Acceptors and Apathetics and Rejectors.

Some of these are available and some will required to be collected.

The scheme to go about this will be discussed in the methodology.

III) Set Forth Objectives

- a) For giving thorough understanding what informations the people will need and what
- b) misconceptions need to be corrected to open up channels for education in public and private sectors of all communities at all levels in the country from the village to the national levels.
- c) To try to form groups of national and communities leaders and their active participation in health education programmes.

- d) To develop proper attitudes among the mass in trying to understand health problems and how they are caused and how to lessen or remove them.
- e) To try to educate people to take actions according to the needs as individuals, families, and communities and a nation.
- f) To plan for the education materials that may be needed according to the educational needs of particular sections of the people at particular levels and places.

Define Constraints and Barriers.

Education and social infrastructures, Agriculture and Industries have been given priority over health. In itself it pose as a constraint as the budget available to Health is much less than needed.

Transport and Communication difficulties; 13. 5% literacy and the different dialect of different ethnic groups.

Difficulties of reaching the remote people due to the ruggedness of the terrain and lack of means of transportation.

Low economic status, poor farmers. 95% people rural population.

General apathy of the people in accepting the "lectures" or ideas of people who are not from their communities.

The constraint and barriers are due to poverty, ignorance and rooted beliefs which require time for change. Small-Pox was regarded as a curse of God "malaria -due to bad water or taking of cheese or yogurt: Now things are no longer believed by most people.

All this has changed considerably but require further changes of thoughts by proper continuous education.

Appraisal of Apparent and potential Resources

Official and private Organizations (Personnel)

Organization, Ministry and Department of Health, Zonal Health Offices, District Health Offices and Health posts etc.

Other Ministries-e. g. Education, Agriculture Home and Panchayat, Forestry, Transport and Communication, Defence etc.

Voluntary Associations, Medical Association, T.B. Association, Red-Cross Society, Family Planning Association, Nurses Association, Paropakar etc.

- iv) Sport clubs, Women's Organization, Labourers Union, Peasants Organization Ex-servicemen Organization, Farmer's Organization, Religious groups, Missionaries and Lions club, Rotary club and Leo Club and others.
- b) Personnel (all others)
 - i) All persons who get in touch with the communities e.g. Community leaders, members of panchayat at different levels. School teachers and others already mentioned in the section "who is to be educated".
All those people need to be educated and they are potential resource that can be used in education the general mass.
 - ii) Personnel actually working in the Health field in the public and private sectors.
 - iii) The people in the community and their contributions towards planning and implementation of programmes.
- c) Materials and equipments needed for the education phase of the programme.
 - i) Mass information resources; the news papers have limited coverage
 - radio-more wide coverage
 - others-movies not available
 - what percentage is covered ?
 - ii) Educational aids - pamphlets, Flip charts, posters, Exhibits, Flannel Graphs, Slide shows etc.
 - iii) Supplies and equipments, Transport to reach the people, equipments projectors, other supplies for producing aids and information materials and locally planned visual aids.
 - d) The financial resources, what is the amount available from official as well as private source. What is the necessary budget. How can it be made available ?

Methods

The ultimate objective of most health education activities is to change individual group, community or social behaviour so that individual health will be obtained and maintained. Communications in some form is a sine-qua-non of all methods and materials

utilised in the practice of health education. Miller states that communication has at its central interest receiver with conscious intent to affect latter's behaviour!! The aim of health education seems to be focussed to the alteration of behaviour which causes illness.

Health education is not merely removal of ignorance. It usually involves in:

- i) Supply of new and correct knowledge about a disease to make few preventive measures required by Scientific Medicine seem reasonable.
- ii) Makes a persons sufficiently keen about the importance of this own health to make him alter his behaviour and adopt preventive measures.
- iii) Makes a person concerned about the health of others and,
- iv) The last and the most important is that it makes person feel strongly about the three already mentioned that he supports and even initiates preventive action by continuous efforts.

METHODS OF EDUCATION

It is generally accepted that the impersonal and persoal methods and their combined action bring about the sequential changes in the knowledge, attitude, bahaviour, habit and custom. Though impersonal methods are simpler and less time-consuming, the personal methods are specially are specially convincing. However, both groups of methods need continual adjustments in the population.

IMPERSONAL METHOD

- (a) These aids are leaflets, slogans, posters, models, flannel graphs Flip charts etc.

These should be designed in a simple and illustrative way and captions should be in plain and simple language.

The value of these aids would increase tremendously if enough material could be propuced so that they were routinely used in all panchayat offices, Schools, places of congregation of people and government offices and all Health Institutions. The missioneries have this system of attracting the attention of people to their social work. With the resources presently available it will be a job to implement this as widely on desirable. People can remember what they see and if re-inforced by personal methods their is a fairly good chance that they will change their behaviour. Planned change is a slow and gradual process needing continuous efforts.

IMPERSONAL METHOD

- (b) Mass

Information sources—Radio, Newspapers periodicals, etc.

These have also limited scope, not all people have access to a radio nor get chance to read news papers or periodicals. However this is important media to disseminate information to all those who can afford radio or a newspaper and have desire to listen to the specific programmes.

The government's social up-life programmes do supply a radio to each village panchayat office and this can be useful when a proper radio programme about health is broadcast.

PERSONAL METHODS

As indicated earlier in this place "word of mouth" travels far and fast in the country. As is customary practice every where community leaders and influential men either in the village or towns have bigger and louder voice in their own communities.

The following will be useful in planning organizing and implementation of health education at various levels.

Non-Governmental

- i) Village town panchayat Members
- ii) School Teachers.
- iii) Community leaders and influential citizens.
- iv) Members of professional organizations
- v) District panchayat members
- vi) National panchayat members
- vii) Religious leaders
- viii) Private sector employed Physicians and other types of medical-care takers.
- ix) Medical Association, T.B. Association, Red-Cross, Family Planning Association, Social clubs and Non-profit organizations.

Governmental

- i) Ministry of Health and its various echelons e.g. Zonal and District Health Offices, Health posts and all their Health Professionals. There is a Health Educator in each of the Zonal Health Office in the present organogram of the Department of Health.
- ii) Ministry of Agriculture, Forestry, Education, Home and Panchayat and others. The

personal method will be used by formation of Committees at all levels by inclusion of panchayat members, Health personal Members from professional organization and members of other Ministries.

They will be themselves educated at the first instance on the following:-

- a) Excreta, sewage and solid waste and refuse disposal.
- b) Safe drinking water
- c) Importance of ventilation and fresh air
- d) Hygiene-personal and community

Diseases of importance and their modes of transmission which will include, incidence, prevalence epidemics, transmission and vectors prophylaxis and treatment, specific relevant information regarding malaria eradication programme, Smallpox, T.B. Leprosy controls will be given and all information regarding

IMMUNIZATION NEEDS FOR PREVENTION against all preventable disease.

- 3) Population pressures, family planning and M.C.H. will be explained and education about need of planned families will cover all aspects of M.C.H. and family planning and nutrition.

4) Nutritional deficiencies.

In simple terms suggested impelcations of nutritional diseases will be explained with possible ways to correct these deficiencies. These groups will organize dissemination of information by individual contact and "word of mouth", group meetings, confrences, taking parts in local fairs and exhibitions, and also taking every opportunity to talk to their Communities through the appropriate radio programmes. Each committee at different level will plan Community Health Edncation with the guidance of Government Health Educationists. The Government will make funds and materials available to these committees through the Department of Health Services as well a local panchayat. If community leaders, men of standing professional groups, Teachers, Social workers and others take part in the planning, impiementation and evaluation the ignorance of the general mass, the obviou apathy and carelessness will be removed to a great extent and gradual but sure and certein change in knowledge, attitude, behaviour, habit and lastly custom can be achieved. This seems to be the only way the attain planned change in Nepal.

If on the other hand a plan is drawn that a basic worker of health will motivate

the people to adopt practices foreign or new to them he/she will not be so influenced to be able to convert the apathetic and rejectors because of the lack of knowledge and necessary qualifications. However when health education is organized along the line discussed earlier the basic health workers can also help to further the goals of the committees as their peripheral agents.

How to motivate for necessary participation and cooperations

VILLAGE LEVEL: At this level the utmost can be achieved by individual contacts interviews, groups discussions, village self head projects, house visits, talks, one-act plays (depicting all the health necessities) exhibitions, Radio broadcasts and most important and popular but least readily available.

MOVIE SHOWS and also posters pamphlets and School Health Education.

Town/ District Level

All of the above and also movies, slides shows, taped talks, models, newspaper.

COORDINATION OF THE PROGRAMME

The Zonal Health Educator will be responsible for coordination of all programmes of Health Education at all levels through the respective health officers usually, and Assistant Health Educator in the District Offices. The difficult part is only the beginning of the process and after a head start is made usually the present increased consciousness among the general mass will itself form a strong force for coordination of activities. The Zonal Health Educator addition will arrange frequent meetings with H.E. Committees for briefings and to bring them up to date.

As priorities, Health Education Committees should be set up and working plans drawn and work carried out in those areas where the mass campaigns Malaria and Smallpox Eradication, Tuberculosis and Leprosy controls and M.C.H. and Family Planning Programmes are already being carried out and will expand. The behavioural changes can be expected to occur through contacts therefore, large proportion of effort will be given towards contact convert! Who in turn spread the information through further contacts. Usually in Nepal if a Head man or a Village leaders accepts or doubts any idea the whole village population also follow him and his whole family will follow it with no questions asked!

Note: The views expressed in the article are interely independent views of the author and has nothing to do with his official status and obligations.

EVALUATION OF PROCESS

that even the selection of goals is value laden containing that good planning must include unanticipated

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