

HEALTH EDUCATION REPORT

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by
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Editor's note: It is suggested that this report be read in conjunction with two earlier reports on Health Education in Egypt, prepared by Nicholas Danforth, Westinghouse Consultant to the Ministry of Health's projects on Strengthening Rural Health Delivery and on Urban Health. Both reports are available at USAID, Cairo.

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EXECUTIVE SUMMARY
Health Education Report
Dr. Raymond Carlaw

Health knowledge, attitudes, and practices in Egypt

The traditional view of disease causation is part of a general concept of misfortune. Natural, social and supernatural influences may all be involved. There is no uniform theory of disease, and the pragmatics of the moment will dictate the appropriate action. The individual is seen as the focus of social influences and tensions which may erupt from time to time as illness. Therefore illness is primarily social in origin. This view is not different in kind from that recently proposed by Symes and others wherein they relate frequency and intensity of illness to social networks, a view in strong contrast to the traditional bio-medical theories.

Health education is an on-going process in any society and occurs in two natural settings. The new generation learns from the old concerning appropriate behavior in avoiding the 'wrath of the gods', pain and discomfort, acceptable definitions of sickness and health and appropriate levels of stress in social relationships. This is part of the cultural fabric.

A second health education process occurs when illness occurs. The individual and the family are the first diagnosticians of illness. Diagnosis is normally confirmed socially and this may be a protracted process if symptoms are unfamiliar. In Egyptian villages the physician is said to be the preferred reference if social and economic conditions allow. However it is questioned whether this reference relates to medical knowledge or to a prestigious social figure whose principal task is to confirm the illness condition - a social role.

Other points of reference within the local community structure are the traditional practitioners. Dayas, circumcisers and bone setters are all available for advice and treatment. Recently a new group of village practitioners has emerged. They are the wives of men employed at the health units and, as entrepreneurs, they have capitalized on trust by the villager and their association with medical treatments to provide an injection and treatment service. There is therefore a natural linkage between the health unit and the village. Unfortunately it is based on quackery rather than medical knowledge. It may be possible, however, to use such linkages.

Health education policies, plans and practices

The Directorate of Health Education and Information, within the Under-Secretary for Development and Research (Ministry of Health), has been functioning for at least three decades. The Directorate is served by a network of 26 sections at the Governorate level and some 70 bureaus. The budget for 1981 is said to be a modest LE 85,000.

Recent policy suggests health education as an integral service of the Health Center Teams in both urban and rural areas. This policy has been translated into an attractive booklet, 5,000 of which have been circulated to 10 Governorates, and others will go out to the others as supplies become available. The book provides an excellent reference for training and it is expected that health team leaders will use it in this way.

The Directorate gives considerable attention to the production of media. Over the last two years some 27 posters have been produced in runs of 20,000 each. These are distributed to health education sections of the Governorates in batches of 500 - 1,000. Twenty-one pamphlets and several films have been made since 1975. There is said to be excellent cooperation with TV and broadcasting and the Director-General plans to put films on video tape for use in cinemobiles.

Museums are also of concern. Museums in pharmacy and in health education exist in Cairo and in several other centers. The models are said to be limited in scope and outdated. New models are required. Some 3,000 children visit these museums annually.

An annual plan for health education is prepared by the Director of Health Education and the Director for Technical Guidance. This is a general statement. This is supplemented with a quarterly plan of about one page giving more specific direction on particular diseases to be addressed by education. Occasional directives are dispatched on emergencies, materials or methods.

Every three years the entire health education staff is given a refresher training course in Cairo for a period of 5 days, and 2 or 3 refresher courses for up to 30 people are held annually.

From January of 1982 a one year diploma course in health education is available to sanitarians who have graduated from the Technical Health Institute. About 40 are enrolled. Teaching is done by the Director-General and by the Director of Health Education, but not on a full time basis.

Thirty hours of health education instruction is provided to Secondary Technical Nurses, Sanitarians and to Laboratory Technicians by physician faculty. A program to train village leaders is being planned.

Difficulties are recognized. A recent WHO report notes that 69% of the units sampled did not have health education materials. Thirty percent had posters

only and none had an active education program. An ECTOR report¹ on the Helwan project reports that health education is irregular and incidental, but that the health education that is offered is on childcare and nutrition. Pamphlets are limited in access as the female non-literate rate is above 50%. "Film audiences are large but are mostly children. The target audience, mothers, are missing."

Priority problems

Mass media: Mass media in and of itself does not change behavior, as several major studies have recently attested. Audio-visuals are aids to teaching and may be aids to learning depending on the salience of the subject and the interest of the observer. Media and A/V technology can provide simulations of reality for teaching purposes. They can also provide simulations of a program unless carefully used. After intention to behave differently has been established, media such as posters and films may help to explain and elucidate. Posters may have value in Health Units if staff incorporate them into a well-designed educational program.

School Health: School may be the most important intervention point in the life cycle. In a period of rapid cultural transition children are responding spontaneously to values and perceptions different from those of their parents. Health and sports are perhaps the only two subjects in the school curriculum which expect psycho-social outcomes and behavior change rather than cognitive reaction. Health therefore requires a different methodology from other subjects -- and a different teacher. There is strength in the Egyptian system because school health is a responsibility of the MOH. There are 7 million children in schools and they represent a powerful intervention point toward improved health behavior in the next generation.

Current status of KAP

The KAP of adults will not change much in any generation unless stimulated by extensive social, educational or economic change. The present KAP is not antithetical to sound health practices and should not involve inter-generational conflict. There is much to be learned from the people for those who would pause to listen, and in the process of dialogue there is change for both members of the dyad. If the community can become concerned with a health issue as diarrhea then they will be willing to adjust their KAP to new parameters -- if they perceive them as valid and useful.

Policy and practice in the public and private sector

Public. The most exciting element in the public sector is the recent concern with community medicine incorporated this year into all medical curricula and into a competency-based curriculum for the certificated nurse. Physicians and nurses now speak of their health education responsibilities and the new High Institute of Nursing at Assiut has community health education as its principal focus. Commitment of these two cadres will provide a functional base for a national effort. To a large degree this depends on the translation of health

education purposes and principles within the curriculum. The expertise of the Institute of Public Health at Alexandria could be used more, as could the demonstration project in oral rehydration.

Private Sector: The community itself is the major resource in the private sector. Communities own the land on which rural health units are erected and through the local government councils have health responsibility, but do they carry it out? A second private sector resource for the future is the Health Insurance Organization. This Organization has a vested economic interest in organizing the use of health care services and in keeping people healthy through education.

Traditional and entrepreneurial practitioners are of the private sector. They have market place plans and practices.

Many donors, both multi-lateral and bi-lateral, have well-formulated policies and plans in the private sector.

National Needs

The greatest health sector need is to re-orient health staff to community interests and to the recognition that health and medical care are not the same thing. The greatest national need is to recognize the enormity of the population problem: unless this is controlled, all efforts of all sectors are in vain. Neither can be overcome by fiat. Each requires skilled education.

Recommendations:

That an intensive review of the structure and function of health education be conducted as a matter of priority with the aim of having the health education process compliment the new community approach in medicine and nursing.

That MOH consider the need for a consultant on health education for up to two years to assist in developing a fresh approach to national strategy in health education.

1. Review and summary of health knowledge, attitudes and practices in Egypt

This will be covered in depth by Dr. Nadim's report. Material available relates to the rural sector and to anthropologists viewpoints. While they are undoubtedly accurate, such studies are often conducted in "remote" areas and represent traditional rather than transitional views.

Health education is a dynamic process operating in every culture at two broad levels. Every child knows from parents and grandparents (from the culture) how to define health and sickness, what foods are good and bad, what behavior and levels of stress are appropriate, and what actions are propitious in avoiding pain and misfortune. A second level of active education occurs when sickness occurs. It is normal to solicit advice on sickness for in every culture the initial diagnosis into the sick role takes place in the home--by the individual or the mother, but usually is confirmed socially.

In rural Egypt illness is casually attributed to the will of God but there is no uniform theory of causation. Illness belongs to a general category of misfortunes and the ultimate cause is social--lying outside of the person. "The body is perceived as a reservoir in which personal problems and interpersonal tensions become manifest on the individual level." (Soheir Morsey 1977) In this belief the villagers' theories are not greatly different from the recent finding of Symes, et al (1978) on a strong relationship between social networks and the frequency and intensity of illness.

Egyptian villagers divide sickness into three broad categories of causation associated with the natural, social and supernatural world. Natural causes such as sunstroke, chills or bad food are recognized and even associated with the socio-economic conditions which underlie exposure to these attributed causes (Morsey). It is believed that there are multiple levels of illness causation and explanations are "highly opportunistic."

Behavioral response to disease varies with the perceived cause, and the resources available to the family. Self-care is common. However, there are several categories of traditional healers to which people turn. The physician is said to be the first choice depending on the immediacy of the situation. Such a choice may not have to do with efficacy of treatment but may refer to perceived power and the social legitimation which the physician's diagnosis provides. The relationship may be more social than biomedical.

Indigenous practitioners include the daya (child birth), the barber (circumcision), and the bone setter (fractures). It is estimated that a maximum of 20-30% of sickness is seen at MOH units, suggesting that traditional practitioners are still active. There are other reports on the decreasing salience of traditional practitioners, in favor of treatment by lower level rural health staff and even by the wives of staff. Injections are popular and syringes and injectables may be purchased by anyone. Some entrepreneurs even mix their own injectables, thereby providing some interesting physiological assaults to bodily integrity. There is a thriving "mid system" treatment which is beyond the scope of this paper but is

mentioned because of the great potential these people have to influence health behavior.

There are divisions of opinion even within the MOH on the present and future role of the *daya*. It would seem that she still has a major influence in the village and while she has been blamed for creating much of the sepsis of child birth, yet she is still the attendant at some 80% of all births in Egypt. The *daya* has several strengths of value to health education:

1. "She communicates in the idiom of the women she serves.
2. She is readily available and relatively inexpensive.
3. Her success and therefor her livelihood depend on the public's evaluation of her abilities and skills." (Hamamsy) "She must, and does, take the time and make the effort to give satisfaction because she has no other place to practice if she is not appreciated by her neighbors." (Thorne and Montague)

The *daya* has the potential to introduce new ideas with the sensitivity and practical intuitiveness of the insider. The *daya* and others in the community who offer treatment and counsel on sickness can be given training in specific areas, and can be a positive influence in the education of mothers for improved child care. The recent P.I.D. proposes this approach and is strongly endorsed.

While the knowledge, attitudes and practices of the villagers do not incorporate a germ theory of communicable disease, they do have beliefs which are not incompatible with recent theory relating to the chronic degenerative diseases. This potential compatibility should be recognized and developed.

2. Review and summary of health education policies, plans and practices

The MOH has maintained a Directorate of Health Education and Information since the 1950s. This directorate is served by 26 sections and 70 bureaus located in all governorates. The Director-General is a physician, as are the directors of 18 of the 26 sections. Five section directors are sanitarians, two are social workers, and one is an arts major. Three have M.P.H. degrees from the High Institute of Public Health. Many directors are said to be appointed against their interest and their will due to pressure to post graduating physicians.

Health education objectives are

- (a) to increase the awareness of disease preventive and health promotive activities among the rural population and
- (b) to strengthen the health service delivery program (in-facility and out-reach) by providing basic health knowledge to the consumer necessary to his optimal utilization of health services.

An Annual Plan for Health Education is prepared by the Director General of Health Education and Information and circulated to all Governorates. This is supplemented by more specific directions in a quarterly plan and by periodic mailings on emergencies, epidemics or methodologies as shown in Table 1.

The health education budget for 1981 was LE 85,000 (compared with LE 300 million for bilharzia). No figures are available on the number of people employed but it would appear to be not less than five at the bureau level, which suggests a total staff of 500 or more.

Current policy is to have health education as an integral service provided by the Health Center Teams in both urban and rural areas. The essence of this policy has recently been written up in an attractive booklet and 5,000 of these have been circulated to MOH units in 10 governorates. All other MOH units will receive copies as supplies come from the printer. The major components of this policy booklet are given in Table 2. This booklet will provide an excellent base for inservice health education training. The Director-General recognizes the need to emphasize health education to expectant mothers, to pre-school and to school children. Immunization, antischistosomiasis, and rehydration were identified as major areas of concern.

There is a strong emphasis on media. Over the last two years a variety of bright posters have been produced. Each run is for 20,000 and these are circulated to health education sections in all governorates (500-1,000 per governorate). Some 21 pamphlets have also been produced as listed in Table 3, together with several films. There is said to be excellent cooperation with TV and broadcasting. In considering programs for the next five years it is hoped to put films on video cassettes for use in cinemobile showing.

Education museums are also a major interest. Museums in pharmacy and health education are located in Cairo, Assiut and Beni Suef, and in "some other governorates." About 3,000 school children are brought to these museums each year, but there are a limited number of museum models and they are said to need replacement and expansion.

The Directorate organizes staff development courses each year. Courses last for 6 days, enroll about 30 staff and are held two or three times a year. An outline of a recent seminar is given in Table 4. The booklet on training is seen as a valuable addition to such courses.

From January of 1982 a one year diploma course in health education is available to sanitarians through the Technical Health Institutes. It is expected that this will produce about 40 graduates annually. The course is taught by Dr. Ateef Abdullah Hussein, the Director-General, and by Dr. Wadei Ghattas Abd El-Malek, the director of the health education division. It is also noted that Secondary Technical Nurses, Sanitarians and Laboratory Technicians have approximately 30 hours of health education in their curricula, all taught by physicians.

A program to train village leaders is being planned. This would be done by Health Unit Staff. Health Education training for home visitors has occurred in 7 governorates and extension is planned.

Difficulties are recognized. A recent WHO report comments:

"For the most part sampled units did not have health education materials. Sixty-nine percent of the units reported that they did not have any materials for health education. The thirty percent which did had posters only and none of the units had an active health education program. The one unit which did have slides and a projector did not use this equipment for health education." (EMRO/WHO 1981, Vol. II p. 37)

Again in commenting on the Helwan zone the HCDS team under ECTOR (Feb., 1981) reports that

"The health education service is irregular, usually incidental.

- Group teaching is frequently done for infant nutrition. The demonstration kitchen is used to prepare a sample food for infants.
- The health education offered is usually concerned with child care and nutrition, maternal care and family planning.
- Neither audio-visual aids nor the pamphlets and books are present." (p. 110)

On pamphlets it is noted that non literacy among women in rural areas exceeds 50% (Female 10 years of age or older, 71% in 1976). On film showings a recent report comments that "most audiences are very large, made up primarily of children, some men, few women: the most important audience for health education, the mothers, are missing". (Danforth, Rural Health Education Summary, 1981).

3. Priority problems related to:

3.1 Mass Media

Posters and pamphlets, in and of themselves, will not affect behavior. They are aids to teaching, and may or may not be aids to learning depending on raliience of the subject and interest of the learners. Print and film (A/V) technology can provide a simulation of reality. It can also provide a simulation for a program where, in fact, none exists. Media is useful after interest and intention to behave has been formed. We avidly read the technical detail in the brochure on a new automobile after the decision to purchase -- not before.

Posters would have value in rural health units if staff had the time and interest to use them. They may affect knowledge but there is no clear cause and effect linkage between knowledge and behavior change.

3.2 School Health

After the approach to the mother and small child the school is the most important arena for change in health concepts and behaviors. It may be the most important intervention point. It is difficult to change the beliefs and behaviors of adults. In a period of rapid cultural transition (Egypt, 1982) children are spontaneously relating to values and perceptions different from those of their parents. School is however a system, unrelated in subject matter from the new school world, and health is perhaps the only subject which is concerned with psycho-social and behavioral outcomes rather than cognitive. Because of this health requires different methodology from other subjects and school teachers generally are unsuccessful as health educators. Their philosophy is cognitive and authoritarian rather than behavioral and interdependent. As MOH is responsible for school health there is an ideal opportunity for health education in the school system of Egypt. At present MOH is concerned with screening and preventive medicine. Consideration could be given to a more active health education program conducted by well qualified M.O.H. health education specialists.

3.3 Current Status of K.A.P.

The knowledge, attitudes and practices of the people of Egypt will change with generation change. It is unreal to expect extensive change within a generation as marked change comes only with marked social, economic or educational change. As most people are poor and have limited education they will be conservative. However, the current belief system is not antithetical to sound health practices and may lie somewhat closer to the "truth" of this decade than some bio-medical theories. The essential element in changing K.A.P. is to create learning situations for people and, in the atmosphere of reflective listening and true dialogue, to build trust and exchange ideas. If the adults of the community can become concerned about the health of children (diarrhea and rehydration) they will be willing to adjust their K.A.P. to new parameters if they perceive them as valid. The K.A.P. of children is much more malleable.

3.4 Policy and practice in the public and private sector

This is a subject for several dissertations.

3.4.1 Public sector

The most exciting element in the public sector is the concern with community medicine. If community is an active part of the equation much can be done. Physicians and nurses speak of their health education responsibilities (see the consultant's Health Sector Assessment report on Health Manpower Training), and commitment by these two cadres will provide an effective base for a national effort:

"As educators, nurses are in a position to facilitate changes in personal and family health attitudes, in such diverse areas as nutrition sanitation and family planning education." (H.S.I. Oct. 1980, p. 6)

Family planning provides the most effective public sector vehicle for health education for the essence of a F.P. program is health education. People cannot be forced into contraceptive use. Health professionals need to recognize that health is not medical care and that behavior change arises from the influence of trust and two way communication, not from authoritarian statements and lectures.

The influence of the sanitarian, the social worker and particularly the midwife has as much potential as the physician and the nurse.

The potential role of the High Institute of Public Health must be noted. It has the capacity through short and longer post graduate courses to affect the thinking of many cadres of health workers and can play a greater part in the health of Egypt.

Another part of the public sector which has great potential as a health education demonstration area is the rural health project (S.R.H.D.). The emphasis on oral rehydration and diarrhea control as a responsibility of the mother provides a "natural" activity involvement and a practical learning experience. The diarrheal disease control project has similar potential. Mothers learn to do something new (behave differently) using their own materials and appropriate technology for purposes that are important to them.

A third area of intense interest is the problem-oriented approach to training physicians at Suez Canal University medical school. This curriculum emphasizes the close link between the health care given and the community members, and the partnership which is essential to the solution of community health problems

3.4.2 Private sector

The Health Insurance Organization, if truly interested in keeping people out of its clinics and hospitals, will develop a health education program. WHO has begun to focus on family formation and the present regional advisor in Health Education/Primary Health Care has a strong community development orientation. The community leaders themselves are private sector. Their interests may not coincide with the priorities of MOH or a governorate, but they will provide energy and initiative for their interests. Working with community leaders is the foundation of any true health education effort. There are also the traditional and entrepreneurial practitioners. Their influence is considerable, especially on women, and ways might be sought to involve them and recognize their worth. Working in the private sector is usually difficult for health professionals. Professionalism and status concerns tend to block communication and to undermine trust.

3.5 National Need

The greatest national need in the health field is the commitment of the health staff to serve the health needs of the people. The change to a team concept and a community orientation will not come quickly. National health needs are

often defined in terms of morbidity and mortality - a biomedical viewpoint. Other definitions are possible, such as psycho-social or socio-economic. There is need to reduce infant mortality; or is there? A major problem, without question, is too many people, and perhaps the national need is to raise awareness of this problem. In the last analysis the people of Egypt will define national health needs, just as the village leaders must be allowed to set their own priorities.

3.6 Previous and current efforts

Current efforts have been described in section 2 above. Time did not allow an investigation of earlier health education efforts, but as current leadership has been in phase for over two decades the approach has probably been fairly stable.

4. Key issues

4.1 Key Issue - Population growth

The current population growth rate is estimated at 2.8%, with a 1982 population of 44 million. This indicates a population of over 70 million by the turn of the century, doubling the needs for food, apartments, schooling and jobs. Any plans in any sector, public or private, have little meaning unless the population growth is curbed. To speak of health plans in the face of population growth of this magnitude is a farce.

Population growth is governed by personal decisions to marry early or late, of women working in the economic sector, of more education, and of the use of contraceptives to space pregnancies and control family size. There is no greater challenge to the education capacities of the Ministry of Health than to educate for smaller family size. This is the essential and dominant key issue.

The best skills and the most effective health education methodologies are warranted. Clearly stated feasible objectives with clearly delineated target groups, and responsibility for time limited achievement are essential to progress and any reasonable quality of life in Egypt. This is an issue of survival and demands a totally committed health education effort.

4.2 Key Issue - Behavior change for improved health

Changes in health behavior will only occur in a community setting based on diverse involvement in a "salient issue". Broad plans have limited value and usually fail. Changes must be small, not disruptive, and developed by and with the community. The challenge of creating the skills in the health staff to work with communities for outcomes defined by the community is foreign to current health staff philosophy and interests. It is, however, a key issue. The knowledge possessed by the traditional practitioners and "entrepreneurs" can be valuable. They are a potentially strong influence in communities and cannot be ignored by health staff.

4.3 Key Issue - M.C.H.

The most important health service to mothers and children in high fertility communities is the ability to plan pregnancies and control fertility. This will impact on the IMR, CMR, and MMR, and result in children with a higher I.Q. and better physical health. Physicians and nurses must understand the salience of spacing of children and of smaller family size as a most effective public health measure. Education in matters affecting fertility affects a sensitive area associated with many well formulated beliefs. Yet trust and open communication can impact on contraceptive behavior for improved mother and child health, as many practicing physicians in Egypt have found.

4.4 Key Issue - School Health

Health education in schools is attractive for reasons outlined in earlier in this report. Children are forming new values and experimenting with new behaviors. A common mistake is to underrate the intelligence of younger children and therefore to propose interventions for groups who have already begun to consolidate their behavior. At about age 10 children begin to separate socially from their parents and to form groups with peers. This unstable period is a particularly useful intervention period, given that it is handled sensitively and with dignity to the child. "The child is father to the man" (or to the woman), and ideas and behaviors introduced in school years have the potential for becoming the norms and accepted behaviors as these children became adults.

School health is fortunate in having able leadership within the M.O.H. Extensive screening has been done and health problems on school entry are well documented. (See the Health Sector Assessment report on Epidemiology and Health Status.) There are 7 million children in school in Egypt, surely a large enough community to interest even the most ambitious.

Areas of direct concern in school are water supply and the use of toilets. Dr. Alia Ayub is experimenting with controlling of lunch breaks so that only 2 or 3 classes (40-70 children) line up to use the half dozen flush toilets at one time. This allows for cleanliness and dignity and is sound health education. The use of individual toilet bags containing plate, cup, towel, soap and tooth brush, labelled by the student and maintained tidily at school, is also sound health education. Health problems associated with schools may become projects for students. Personal aspirations and a sense of dignity are powerful motivators.

4.5 Key Issue - Bilharzia

The use of molluscicides and prophylactic medication is costly and limited in effect. Unlike the host snail in Asia the snail in Egypt floats and thus is difficult to eradicate. Given a large surplus of child labor in Egypt it is conceivable that a health education project may involve children in netting snails from the canals, in a similar community effort to that of the Chinese in eliminating snails from ditches. Children (and adults) might be taught the

bilharzia transmission cycle, given a fine mesh net, and rewarded with say 5 piastres per 100 snails. Active involvement in prevention is a direct health education methodology and might be absorbed by the bilharzia budget.

4.6 Issue - Leadership in health education

Given the primary importance of community involvement in improving the nation's health, and the strong orientation to community medicine reflected in the medical and nursing curriculum, it is important that the official health education program both support and work with all health service delivery units to capitalize on the fresh approach to health care in Egypt. There is therefore a strong case to be made for developing the leadership orientation in the health education directorates and governorates toward a community view of health education.

4.7 Issue - Patient education

An increasing number of people suffer from chronic disease in Egypt. Diabetes, Cancer and Heart are becoming important morbidity problems. There is need for hospital-based patient education, to cope with pain and death, and to educate for rehabilitation and self care.

5. Recommendations

5.1 That an intensive review of health education structure and function be instituted as a priority, with the joint purpose of having the health education process compliment the new approach to the training of physicians, nurses and technicians - and for developing the interface of rural health units with their host communities.

5.2 That M.O.H. consider the need for a consultant in health education for two years, to work with M.O.H. and governorates in developing a fresh approach to national strategy in health education.

Table 1.* HEALTH EDUCATION PLANS, POLICY, AND PROGRAM DIRECTIVES FROM MOH TO HEALTH EDUCATION SECTIONS IN GOVERNORATES*

<u>DIRECTIVE</u>	<u>PREPARED BY</u>	<u>EXPLANATION</u>
Annual Plan	Director of HE section/ and Director for Technical guidance.	A general outline of health education activities for the coming year. Not specific about educational or behavioral objectives, target groups, evaluation measures, etc.
Quarterly Plan	Same as above, with assist- ance from preventive health section.	more specific direction about what diseases to focus on during the coming three months; contains less than one page of direction; no evaluation measures; no description of educational methods to be used.
Periodic Mailings	Director for Technical guid- ance with support from various MOH department, WHO, and other interna- tional agencies.	Occasional directives are distributed by MOH in case of yearly special campaigns (polio, TB) or emergency (epidemic, natural disaster) and regularly to inform staff about new educational methods, sample materials, newsletters, manuals, etc.
Every three years training at MOH in Cairo for 5 days.	Entire HE staff of MOH, assisted by various other MOH officials related to HE.	All Health Education Section and Bureau Directors are required to take this refresher in-service training course (see above for outline of recent MOH course). Policy and programs are discussed during this training.

*Editor's note: This page appeared as an annex to an April 1981 report for the Strengthening Rural Health Delivery Project by Westinghouse Health Education Consultant Nicholas Danforth.

Table 2

Guide Lines for Work of Health
Education to the Health Team

By Dr. Atef Abdallah Hussein

- What is meant by Health Education?
- What are the objectives of Health Education and its importance?
- How can a successful plan of Health Education can be implemented?
- What are the foundations for successful health education for the work of a health team?
- The duties of a health team in rural & urban health care units with regard to health education (doctors - health supervisor - social worker)
- The role of school in educating and developing health habits for students.
- The duties of doctors and health teams in the field of school health education.
- Some health guidelines which can be taught to students.
- Health Education and a plan to solve the problem of the spread of eye-diseases.
- Some points which should stressed in health education in a plan to solve the problem of flies.
- Health Education and a plan to solve the problem of diseases which can be spread through.

Table 3 *

Subjects of MOH Health Education Pamphlets and Films in circulation, 1981*

<u>Pamphlets</u>	<u>Posters</u>
Glaucoma	
Family Planning (general)	Schistosomiasis 2
Quarantine	Smoking 3
Family planning for youth	Tuberculosis 2
Family planning and family care	Family Planning 1
Health care of the elderly	Measles 1
Children's vaccinations	Immunization 1
Diarrhea in children	Blood Donation 2
Poliomyelitis	Nutrition 10
Scabies	Malaria 1
Malaria	Filaria 1
Infectious hepatitis and jaundice	Breast Feeding 1
Rabies	Case of Teeth 1
A Drug is a double-edged sword	Coughing 1
Bilharzia prevention by health education	27
Filaria (elephantiasis)	
Intestinal Parasites	
First aid for school children	
Mother and child care	
Summer diseases	
<u>Anti-smoking</u>	
21	

MOH Health Education Films (since 1975)

<u>Subject</u>	<u>Minutes</u>	<u>Subject</u>	<u>Minutes</u>
Bilharzia	15	Measles vaccination	2
Bilharzia	24	Vaccination-general	5
Smoking (3)	1	Blood donation	4
TB	8	Blood donation	3
TB	3	Public health (10)	2
Drugs	6	Polio vaccination (6)	1
Family Planning	5		

* Editor's note: Modified by author (by addition of list of posters) from an annex to a report developed for the Strengthening Rural Health Delivery Project by Westinghouse Health Education Consultant Nicholas Danforth.

Table 4

MINISTRY OF Health
Gen. Dept. For Health Education
Mass Information

Program of Seminar 1981
Attended by Director of Depts. & Health
Education Bureaus in Governorates

- "Opening Speech", by Dr. Abdel Ghafar Khalaf, Under Secretary
- "The Meaning of Health Education and its objectives",
by Dr. Mohamed Labib Ibrahim.
- "Health Education as work of the health team in the main health
care units in rural and urban places", by Dr. Atef Abdallah
Hussein, Director General.
- "Ways and Means of Health Education and the coordination between
health education units and other concerned organizations to the
masses", by Dr. Wadiea Gatas Abdel Malak.
- "The role of Health Education in the services of child and
mother care" by Lotfy El-Sayad.
- "The role of Health Education in the services and combatting
tropical diseases", by Dr. Osman El Zeinaty.
- "The role of Health Education in the services and combatting
tropical diseases", by Dr. Mustafa Hammami.
- "The role of Health Education in the services of contagious
diseases", by Dr. Saleh Madkour.
- "The activities of the Health Education units or bureaus", by
George Fouad Nomman.
- "The role of Health Education in the field of family planning",
by Dr. Atef Abdallah.
- "How to budget Health Education on the Governorate level", by
Ahmed Abdel Hafez.
- "A meeting to explore and discuss work problems" participated by
Dr. Atef Abdallah, Dr. Wadie Gatas Abdel Malak, Mr. George Fouad
and Mr. Lethy Dawoud Azab.

ANNEX B

People Consulted in Health Education

Dr. Atef Abdallah Hussein MOH, Dir. Gen. Health Education

Dr. Wadei Ghattas Abdel Malek MOH, Dir. Gen. Director of Health
Education

Dr. Gamal Sharrom MOH, Director of Audio-Visuals

Dr. Alia Ayub MOH, Director General of School
Health

Dr. Tomic WHO, Regional Advisor in Primary
Health Care, and in Health Education

In addition, discussions on health education were held with many of those consulted on health manpower training.