

**Health Education in
Primary Health Care Projects:
A Critical Review
of Various Approaches**

by

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&

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INTRODUCTION

Health education is an important activity of health programs in child survival, reproductive health, nutrition and AIDS care and prevention implemented by non-government organizations (NGOs) in developing countries. These NGO health programs are usually undertaken within the framework of an overall primary health care national policy.

The 1978 Alma Ata International Conference on Primary Health Care defined primary health care as “a practical approach to making essential health care universally accessible to individuals and facilities in the community in an acceptable and affordable way and with their full participation” (WHO 1978). Primary health care is based on concepts of equity, community self-reliance, decentralization of health services and integration of social and economic development (Marsick and Smedly 1989). While this credo was adopted by over 100 countries, actual implementation of primary health care over the past two decades has been difficult for many governments due to conflicting political, social and economic realities (Latham 1996). The Alma Ata declaration designated “education concerning prevailing health problems and the methods of preventing and controlling them” the first of eight essential elements of primary health care.

Given the important place of health education in focused health programs, **the purpose of this paper is to offer NGOs¹ and other interested organizations a comparative review of health education approaches and research and data collection methodologies associated with them.** The paper will explicitly highlight differences and similarities in the theoretical base, worldview and problem analysis of different health education approaches. The review includes a series of case studies to provide readers examples of how the approaches have been applied in the field. It also includes a set of questions to assist NGO headquarters and field staff to critically analyze choices about the particular health education approach best suited to their situation, and more deliberately choose an approach that is congruent with their organization’s goals and values.²

Definitions of Health Education

Health education has been variously defined by Green (1980) as any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health; by Simonds (1976) as a strategy aimed at bringing about behavioral changes in individuals, groups and larger populations from behaviors detrimental to health to behaviors conducive to present and future health; and by Werner and Bower (1982) as a strategy to help the poor and powerless gain greater control over their health and their lives. Health education is sometimes subsumed under the term “health promotion.” Health promotion is perceived to encompass health education while also including complementary political and social actions that will facilitate the necessary organizational, economic and other environmental supports for the conversion of individual actions into better health status (Green and Kreuter 1991).

However, Glanz, Lewis and Rimer (1990) describe an ecological perspective of health education which includes intrapersonal factors (knowledge, attitudes, behavior, self-concept and skills); interpersonal

¹ Though this paper is being distributed in the first instance to US-based Private Voluntary Organizations (PVOs), it is our hope that they will share it with their local partners (public and private) in the field. Hereafter, therefore PVOs will be referred to by the more common term – NGO.

² Readers will notice that counseling – either counseling of patients by health workers or various forms of peer counseling, which are important forms of health education – are not explicitly dealt with here. Various forms of counseling may be philosophically/theoretically related to a number of the approaches described here (for example peer counseling may draw implicitly or explicitly on popular education approaches) but are not described separately.

processes and groups (social support systems, families, work groups and friendship networks); institutional factors (social institutions with organizational characteristics); community factors (relationships among organizations, institutions and informal networks within defined boundaries); and public policy (local and national laws and policies). These health educators argue that the concept of health education has always included a broad social mission. In this paper, health education will be used in this broader perspective.

NGO Health Education Approaches in Developing Countries

A large range of health education and related data collection activities exist within NGO health programs. These activities may include anything from peer education for AIDS prevention, to training of government health workers in growth monitoring and promotion, to educating village caretakers in oral rehydration therapy, to social marketing of child feeding behaviors, or to community mobilization for safe motherhood practices. The particular health education approach underlying a health education intervention may be undefined or vague, may refer to an eclectic mix of educational and communication theories, or may be more strictly linked to a particular theory and its accompanying educational and research methodologies. Furthermore, many NGO health educators claim that their approaches promote participation and empowerment of participants while others focus primarily on issues of efficiency and the behavioral results achieved.

Two main issues emerge from a review of NGO health education in practice and in literature. The first issue has to do with the implications of whether or not NGO health education practice is explicitly linked to theoretical, conceptual and philosophical frameworks. The second issue involves debate and the existence of tensions among proponents of different health education approaches.

Green (1990) (paraphrasing Kurt Lewin whose behavioral research greatly influenced contemporary health education) states that “If it is true that there is nothing so practical as a good theory, then one must wonder why so much practice in health education is atheoretical.” An atheoretical approach to health education would be troubling to those health educators who argue that the benefits of health education programs are most likely to occur when the program is directed by a theory of health behavior which helps to identify targets, methods and evaluation of change efforts (Glanz, Lewis and Rimer 1990).

Other health educators have similar views regarding the absence of explicit philosophical positions or statements of values. In the field of nutrition, Sobel (1991) writes that nutrition educators need to develop capabilities for explicitly recognizing the moral positions underlying the actions they take and for understanding the philosophical justifications for their actions. Caplan (1993) holds a similar view for the field of health promotion, arguing that health educators should better understand the theoretical and philosophical assumptions that underlie methodological preferences. **All of these authors would agree that NGOs need to be clearer about both the theory and worldview (i.e. assumptions about the learner and the teacher and the meaning and goal of education) underlying their health education efforts.** This paper seeks to provide a first step in understanding the theory and worldview of several broad health education approaches.

Beyond understanding theory and worldview, **practitioners should also be aware of the inherent tensions that exist between the different approaches** (precisely because of the way they differ in their views of health and education). This understanding is part of the critical analysis process that will enable NGOs to more deliberately choose their approach(es). The paper provides a brief review of the inherent tensions that exist among approaches and the critiques each has of the others.

COMPARATIVE REVIEW OF HEALTH EDUCATION APPROACHES

The task of categorizing and labeling different educational approaches used in the field of health is difficult. **There is overlap between educational approaches and some readers may disagree with the choice of labels and distinctions.** The authors acknowledge this difficulty and welcome further discussion and debate that will assist NGOs in the selection, justification, planning, implementation and evaluation of the particular health education approach best suited to their situation and goals.

Approach in this Paper

Three main health education approaches, some with key sub-components, were selected for discussion and analysis in this paper. These main approaches and sub-components include:

- I. Conventional Health Education
- II. Health Communication
 - A. Social Marketing
 - B. Behavior Change Communication
- III. Health Education for Empowerment
 - A. Popular Education
 - B. Community Organization

Each health education approach and sub-component is described and analyzed in a narrative section. This information is also summarized in a matrix found at the end of the paper.

Glanz, Lewis and Rimer (1990) distinguish typologies of health behavior change through education according to models of individual health behavior, interpersonal health behavior and group intervention. In contrast, this paper distinguishes health education approaches using the following typology:

- **Explicit or implicit worldview** (What is the meaning of education? What is the goal of the educational intervention? What is the role of the teacher/facilitator and student/participant?)
- **Theoretical basis** (What are the ways, processes, or mechanisms by which health behavior is affected? What are the generalized abstractions applicable to a wide range of experiences?)
- **Historical roots**
- **Associated educational methodologies**
- **Resources needed** (general assessment of the time, personnel and funds required for the particular approach)

The review includes a description of research and data collection methodologies associated with each approach and critiques of each approach. It also includes brief examples of the circumstances in which each approach might be appropriately used. After the approaches are described, a discussion of the inherent tensions that exist among them is presented. Finally, short case studies of actual health education activities are used to illustrate the application of these various approaches in field settings.

A simple example from Haiti illustrates how these different approaches *might* address a health problem. In Haiti, one contributing factor to child malnutrition is the practice of leaving small children with a young, uneducated child minder, perhaps an older sibling. Women must travel to far-off markets in order to ensure their families' economic survival. Many women feel it is wrong to take small children with them due to the hardship of the trip, the exposure to the elements of a hot and dusty market, and the fact that Haitian women do not carry children in a sling. A didactic, **conventional education** approach focuses on transfer of knowledge and might result in a health education design whereby the child minders are trained in knowledge of better child feeding practices. A **social marketing approach** might result in development and marketing of an easy-to-give nutritious product or drink that child minders can give to children during the day. A **BCC approach** might focus on changing behaviors of both the child minders and mothers to perhaps teach mothers to leave behind nutritious food that won't be spoiled and to teach child minders how to feed children correctly. A BCC approach might even experiment with introduction of slings to women in order to enable them to take children to markets or introduction of covered areas within markets. An **empowerment approach** would begin by inquiring why women are forced to go to far-away markets to the detriment of their children's health? What in the community or larger society makes this necessary and what societal changes are necessary to enable women to meet these conflicting needs within their family? Health education here might focus on sharing work within traditional community networks or seeing if men could be involved to lighten women's workloads.

Conventional Health Education

Characteristics

Conventional health education refers to approaches that **emphasize knowledge acquisition**. These approaches focus more on **individual knowledge, attitudes and beliefs**. Mental processes are emphasized such as thinking, reasoning, hypothesizing or expecting (Deshler and Kiely 1995). Health educators using this approach assume that the greatest obstacle to better health is ignorance and thus their job is to deliver accumulated knowledge and impart technical skills.

In the field of nutrition education Hornik (1985, 1988) and Israel and Tighe (1984) refer to conventional nutrition education as didactic, stressing knowledge acquisition rather than behavioral change. Olson and Cerqueira (1995) describe conventional nutrition education as that influenced by a medical model in which nutritional counseling to mothers of malnourished children is perceived as a prescription for curing disease, driven by nutritional science rather than the mother's concerns. Indeed, several texts illustrate this approach to health education by picturing a white-uniformed doctor or nurse lecturing to mothers on a particular health topic (Werner and Bower 1984 and Srinivasan 1992).

In conventional health education, the teacher's role may range from an authoritarian or expert figure using didactic methods with passive learners to that of a facilitator using methods developed by cognitive theorists with active learners. **Knowledge acquisition, however, is the goal** of either extreme. Werner and Bower (1984) describe a villager's reaction to the didactic approach as:

“This is the way most of us were taught in school. The teacher is the boss. The students are considered to know nothing. They are expected simply to repeat what they're told.”

Didactic styles often emerge when the teacher has been trained in the technical content of the subject but has little or no pedagogical skills or training. Intuitively, these teachers, trainers or educators draw from their own past experience in formal education. Vella (1995) writes that unless an educator's training provides them with a new experience of education, as teachers, they will revert to their known framework or their familiar model. In contrast to the authoritarian didactic teacher, a conventional health educator may also take on a facilitator's role in organizing information and materials so that learners can assimilate them meaningfully into their knowledge structures. However, in contrast to popular educators (see below) who also play the role of facilitator, the conventional educator focuses *only* on knowledge acquisition (and not critical thinking on the part of learners about the assumptions underlying the knowledge or how it relates to their reality).

Didactic approaches are traditionally the mode of learning in the formal education systems around the world for primary, secondary and higher education. Srinivasan (1992) writes that the didactic instructional style has for years been a most-favored vehicle for delivery of accumulated knowledge and imparting technical skills which agencies decide are needed by people.

Didactic approaches use educational methodologies based on rote learning and rely on lectures given to learners. Shor (1992) describes this as “one-way teacher talk.” Conventional education drawing from cognitive theorists often use methodologies such as concept mapping (visually recording relationships between connected concepts); metaphors, analogies and similes to bridge prior knowledge and new knowledge and organizing strategies where the learner is helped to rationally order, classify or arrange information in categories such as typologies or similarities and differences (Deshler and Kiely 1995).

The conventional education approach requires less resources than other health education approaches. This is because the sponsoring agency can select the content to be delivered, and organize and package it well ahead of time in a curriculum. The instructor's job is simplified because the information appropriate to any learning group has already been prescribed by professionals. Evaluation is also simplified because it involves tests to determine if content has been assimilated as taught and can be correctly recalled (Srinivasan 1992).

Research and Data Collection Methodologies Used in the Conventional Health Education Approach

The didactic approach relies on research and data collection methodologies such as baseline studies where specialists determine the gap between what people know and what they need to know, i.e. the required coping skills. Monitoring of educational performance is done in terms of the number of presentations made or demonstrations conducted to determine whether the content delivery system is functioning as originally planned. **People's ability to recall the right answers is taken as a reliable indicator that the messages have been properly received** (Srinivasan 1992).

Critiques of the Conventional Health Education Approach

Conventional health education and in particular, the didactic approach is sharply criticized by proponents of all the other health education approaches. The distinctive goals and worldviews of each of the other health education approaches shape these critiques. For example, empowerment educational proponents (see below) are **troubled by the structure of control by outside expertise in the didactic approach where learners have little or no say**. Freire views this approach (which he calls "banking" education) as a means to reinforce oppressed people's feelings of inadequacy and dependency on outside sources. Further, he thinks that the content of conventional education is alien to the life experiences of those being taught (Freire 1996). Empowerment proponents dislike the didactic goal of "closing the knowledge gap" and "acquiring and storing knowledge", preferring a definition of education based on the word's latin roots which mean to develop from within, to educate or to draw out (Srinivasan 1992).

Health communication proponents (see below) center their critique on **the inefficiency of didactic approaches to effect positive behavior change and subsequently positive changes in health status**. Hornik (1985) and Gillespie and Mason (1991) view conventional nutrition education as ineffective and unsuccessful because of limited reach, poor message design, lack of adequate research and bias towards relying solely on interpersonal communication. Braun et al (1994) point out that program planners no longer assume that if people are given information they will change their behaviors and Murray et al (1997) stress the focus on health-related behaviors in order to have measurable impact on childhood morbidity and mortality in developing countries. Graeff, Elder and Booth (1992) write that in order to reduce morbidity and mortality, health programs must go beyond simply educating the public.

Health Communication

Health communication has been defined as the modification of human behavior and environmental factors related to behaviors which directly or indirectly promote health, prevent illness or protect individuals

Situations in which Conventional Health Education Might be Appropriate

- ◆ When time is critical or there is a need to reach large masses of people with basic information – as in rapidly spreading or especially virulent epidemics or sudden environmental threats.
- ◆ When simple explanations on a previously agreed-upon solution are needed – as in how to use socially acceptable medicines or family planning.

Note: Conventional health education in these situations still need not be utilized as a didactic approach.

from harm. Health communication and its related fields represent systematic attempts to influence positively the health practices of large populations. **The primary goal of health communication approaches is to bring about improvements in health-related practices and in turn, health status** (Graeff, Elder and Booth 1993).

Social marketing and behavior change communication will be analyzed as key sub-components of the larger field of health communication. **Social marketing** is usually conceived as a methodology used in health communication or a theory contributing to health communication. However, its distinctive concepts and theory base deserve detailed attention. The term **behavior change communication** represents the most current terminology used in the field of health communication for efforts variously called health education, health promotion or IEC which stands for information, education and communication (Graeff, Elder and Booth 1993; Flanagan 1996).

Behavior change communication grew out of USAID's experiences over two decades of development communication (Flanagan 1996). In the 1970s and 1980s, behavior change approaches were used in the United States to combat chronic diseases, targeting smoking and high-fat diets. In the 1980s, international donors and government representatives of developing countries began to explore similar behavior change approaches through health communication to support child survival techniques and practices (Graeff, Elder and Booth 1993). An example is the USAID-funded project called HEALTHCOM, designed to help developing countries and USAID missions increase the effectiveness of their health and child survival programs through improved communication and social marketing activities (Seidel 1993).

Social Marketing Characteristics

Novelli (1990) defines social marketing as the design, implementation and control of programs seeking to **increase acceptability of social ideas or practices in target groups**. Braun et al (1994) write that social marketing is a client-focused process for designing and implementing a program that promotes **voluntary adoption** of a socially beneficial idea, service, practice or product by increasing benefits, decreasing barriers and offering **strong, persuasive messages or communication**. According to Manoff (1985) social marketing's purpose is to create broad public awareness of critical public health issues and its goal is improved public health. Social marketing proponents see it as a strategy for translating scientific findings about health and nutrition into education and action programs (Manoff 1985).

Situations in which Social Marketing Might be Appropriate

- ◆ When a new product responds to an already known need in a population – as when a desire for contraception exists, social marketing can publicize the availability of new methods.
- ◆ When a practice has negative images associated with it and demand or acceptance is to be created.
- ◆ When commercial interests (cigarette or infant formula sales) are to be confronted.

Social marketing's strategy is formulated by Orlandi et al (1990) as an engine for worldwide health promotion efforts **to diffuse viable innovations from those who have them to those who need them**. Social marketing often refers to people as consumers, audience members or target audiences. Behaviors are equated with products which social marketing makes more accessible through lower costs and creation of consumer demand (Braun et al. 1994). The social marketing approach is systematic and appeals particularly to technical specialists like public health officials and communication experts involved in the project approach to development, because all the stages of the program can be clearly mapped out in advance with targets and objectives (McKee 1992).

The origins of social marketing can be found in the success of American advertising of commercial products and some successful uses of mass media to change behavior related to health. Its principles are simple and straightforward. It assumes that if the public can be made widely aware of a product available at affordable prices and be persuaded of its benefits, people will purchase the product. It derives its principles from a blend of marketing and communication. From marketing comes the theory of exchange that posits that individual groups or organizations have resources that they are willing to exchange for perceived benefits such as goods, services or ideas. **Voluntary exchanges are elicited by offering benefits that are valued** (Novelli 1990). Optimal marketing mixes are created through attention to the product, the price of the product, the place where the product moves to users and promotion such as advertising (Braun et al 1994). From communication theory comes the idea that, provided that appropriate messages are formulated, mass media as well as interpersonal channels can be used to inform the public about the virtues and availability of a product.

Social marketing also incorporates concepts from other learning traditions such as **diffusion of innovations** (Novelli 1990; Griffiths 1993). Diffusion is defined as the process by which an innovation is communicated through certain channels over time among members of a social system. An innovation is an idea, practice or service that is perceived as new by an individual, group, community or institution (Orlandi et al 1990). Diffusion of innovation was popularized by Everett Rogers in the 1960s and was used to develop agricultural extension systems based on development models of technical transfer (Ewert 1989). Later versions of the diffusion of innovation concept were modified to stress the importance of social factors in learning new behaviors and communication as a two-way process of convergence.

See Case Study 1: Condom Social Marketing on page 22. Most condom social marketing projects aim to make condoms affordable, available, and attractive.

Interest in social marketing was heightened in the early 1980s when the government of Indonesia presented the results of the Nutrition Communication and Behavior Change Project. This project documented that social marketing principles applied to nutrition education improved not only nutrition related practices but also the nutritional status of children. Nutrition policy advisors viewed this as the first time that a quantifiable change in nutritional status had been measured as a result of an educational intervention (Griffiths 1993). Social marketing has one clear advantage lacking in other approaches when viewed from the perspective of health educators. It is a method of research, message development, and communication that can be programmed and directed technically from the outside, while still conducting some research with segments of a population about local priorities or preferences.

Social marketing uses sophisticated methods to identify target audiences, a process referred to as audience segmentation and identifies groups, for example pharmacists, who were often overlooked in past health education efforts. Social marketing stresses thorough situation analysis, consumer (focus group) and market research, formative evaluation and demographic analysis (Manoff 1985). After this complex research process, communication channels are identified and messages developed that are simple, directed towards behavioral and life-style changes and characterized by **emotive and persuasive power**. Mass media is often (but not always) used in that it extends the reach of messages, carries a special authority, assures control of messages and enhances the effectiveness of other health education methodologies (Manoff 1985).

Many health projects funded by USAID have incorporated social marketing as an organizing principle for large-scale national interventions in breast-feeding promotion, condom use, treatment of STDs and immunization (Braun et al 1994; Griffiths 1993). While a considerable investment in resources is required for social marketing, it is perceived as an efficient investment to achieve its goals. For example, in Africa where condoms were historically unpopular and unused, a large social marketing program dramatically increased condom sales (Frank 1995). Manoff (1985) writes that social marketing fills a critical gap in public health because there is a shortage of physicians who, at any rate, are more oriented to curative rather than preventive health care.

Behavior Change Communication Characteristics

Proponents of behavior change communication (BCC) draw on a combination of health communication theory and epidemiology to persuade populations to adopt behaviors that reduce their risk of disease. Using the results of epidemiological studies to define relevant health problems, and conducting interviews and focus group discussions to learn how people conceive of health problems, they seek to use mass media and interpersonal communication to persuade people to change their behaviors. Research serves to identify barriers to behavior change and to examine the feasibility of adopting new behaviors.

The model of behavior change that underlies health communication theory and the BCC approach originates in social psychology, and stems from three separate models: the Health Belief Model (HBM), the Theory of Reasoned Action (TRA), and social learning theory. The HBM was first developed in the 1950s to better understand low public compliance with preventive health measures in the United States. It focuses on individual belief and knowledge of factors related to health problems: how individuals perceive the threat to their own health, how they judge severity, and how they evaluate the costs and benefits of health services. As formulated by Fishbein and Ajzen (1975), the Theory of Reasoned Action is designed to predict individual behavior by focusing on four dimensions: affect, cognition, intention, and behavior, and the relationship among them. This approach uses large sample surveys to measure these elements and how they change over time.

See Case Study 2: Hearth Programs on page 23. Hearth programs illustrate the move in nutrition education from a conventional education approach to one which straddles behavior change communication (drawing heavily on social learning theory) and empowerment education.

Social learning theory (SLT) formulated by Allan Bandura (1986, 1989) assumes that individuals learn how to act by modeling their behavior on that of others and by finding social reinforcement toward certain actions. SLT pays close attention to what is called self-efficacy, the perceived ability of an individual to perform a specific behavior. In this approach, communication programs that are able to change individual perceptions of their ability to perform certain actions are expected to be able to change behaviors.

Situations in which Behavior-Change Communication Might be Appropriate

- ◆ When proposed changes in practice must be negotiated directly with those to whom the change is being proposed – as in proposing changes in infant feeding practices to mothers or other care givers.
- ◆ When there is evidence that individual action/change is possible in a given context for a given health issue.

The HBM was used to predict behavior change in the more traditional health education programs in the US, and then became part of implicit understandings about behavior change in the common sense views of public health specialists. This can be seen in the way public health experts call upon anthropologists to conduct research on local beliefs to explain behavior. These models are attractive in that they provide directions for measuring program impact. That is, the TRA asserts that there is a close relationship between attitudes, beliefs, intentions, and behavior, and that changes in attitudes and beliefs will engender changes in intentions and behavior. If this is so then it is possible to measure

changes in these dimensions over time with before and after surveys. The current push for clear indicators and impact evaluation of health projects increases the attractiveness of these approaches.

These approaches all conceive of culture as a likely barrier to desired behavior change, as a set of beliefs, values, and individual goals that pattern behavior. In this view, if we find that individuals hold beliefs that should be changed to improve health status, they should be persuaded to change their beliefs and understand alternative goals so their behavior will change.

Behavior change communication distinguishes itself from conventional educational approaches that “simply provide information.” While the fundamental goal of health communication and BCC is to influence or improve health behavior, BCC proponents emphasize the involvement of “target audiences” in the **negotiation of health behavior interventions as opposed to making prescriptive health messages**. The involvement of target audiences is perceived as beneficial for several reasons including increased chances that the recommended behavior will be technically appropriate; sustainability of the behavior; and that it is simply more ethical (Braun et al 1994). The main purpose of behavior change communication is to give people the knowledge, skills, encouragement and support they need for more healthy living (Flanagan 1996). **Learners are “target audiences” and assist communication experts to develop messages.**

Interaction with target audiences is accomplished by communicators who dialogue with target audience representatives through ongoing systematic research. Community members are involved in BCC in order to plan communication strategies and activities based on the community’s needs, culture and practices. Planned strategies are tested with communities before being delivered on a mass scale and ongoing research with the communities allows communication strategies to be fine-tuned (Graeff, Elder and Booth 1993; Braun et al 1994). The hallmark of behavior change communication is **effective message development through reinforcing communication channels** (Hornik 1988). BCC’s channels or means are wide-ranging and include peer education, mass media communication in print, television and radio, education of influential policy-makers, and popular forms of communication such as theater or art (Flanagan 1996).

Behavior change communication has been applied in USAID-funded projects such as the AIDS Control and Prevention (AIDSCAP) project and is recommended as a methodology for community primary health care programs in the BASIC’s document entitled “Emphasis Behaviors in Maternal and Child Health: Focusing on Caretaker Behaviors to Develop Maternal and Child Health Programs in Communities.” Like social marketing, BCC focuses directly on behavior itself and does not concern itself as much with knowledge and attitude changes (Graeff, Elder and Booth 1993).

See Case Study 3: The RICHES Project on page 26. The RICHES project illustrates a behavior change communication education approach emphasizing message delivery through interpersonal communication to teach rural Haitian women health and nutrition topics.

BCC approaches are used by larger community service organizations (such as the Academy for Educational Development) who have large research capacities in comparison to NGOs and usually conceptualize programs on a nationwide or even regional basis. There are examples of NGOs who have applied BCC approaches on a smaller scale and certainly many NGOs incorporate message delivery in health education. Technical assistance given by projects such as AIDSCAP, provided smaller NGOs with consultants versed in the BCC approach.

Research and Data Collection Methodologies used in Health Communication Approaches

Health communication research and data collection approaches begin with the results of epidemiological research. In the realm of child survival, for example, behaviors are pre-selected that are likely to have a significant impact on childhood morbidity and mortality; are cost-effective; and can be feasibly maintained over time (Murray et al. 1997).

BCC relies on formative behavioral research that clarifies risk behaviors and their determinants. Formative research for BCC involves analysis at both the community level through situation analysis and individual investigation through audience research (Flanagan 1996). Much attention is paid to the adaptation of messages to the

See Case Study 4: The Weaning Project on page 28. This project illustrates a behavior change communication approach.

conceptual frameworks of the target audiences to increase the cultural acceptability of health messages. Rapid assessment procedures (RAP) and other methods that draw on applied anthropology, including focused ethnographic studies, focus group discussions, direct observations and KAPB surveys, are often used to understand the “why” of certain behaviors and the factors that might enhance or constrain behavior change (Braun et al. 1994).³ KAPB surveys and qualitative research is also used to understand communication channels and the most effective media/means to communicate the set of pre-determined health messages.

Research and data collection methodologies used in health communication are largely extractive⁴. Information is “extracted” from informants in order to improve the quality of the communication strategy but the basic themes to be communicated have already largely been determined from the outside. Messages may also be tested (via focus groups, a qualitative research tool) for recognition and understanding but the basic content is set by experts.

While RAP is more open to and inquisitive of people concerning their perceptions of health – their knowledge, attitudes and practices - and is concerned with indigenous perceptions of health-it is still largely extractive. Information is collected and processed to provide a “road map” (see Scrimshaw and Hurtado 1987) of cultural domains or ethnoclassifications. This information is then analyzed away from the informants and used to develop messages and approaches to communication. As Herman and Bentley (1993) note: “The RAP methodology facilitates the identification of improved strategies for communicating recommendations effectively within a specific cultural context. It identifies beliefs about causes of illness and its consequences that vary from culture to culture.” Scrimshaw and Gleason (1992) note that RAP evolved out of the need to have more in-depth information and understanding in order to develop more effective child survival strategies. Child survival planning began with an intervention and often a strategic framework based on known data. However, in-depth knowledge of the community was needed to adapt and develop a strategy which would effectively deliver a service or achieve a desired behavior change among the project’s clients.

This research can focus on barriers/enabling factors as well as beliefs and attitudes, but the information is not the property of the informants who supplied it. Instead, they are seen as clients or the target of BCC. RAP draws on a large body of literature and experience from applied anthropology and emphasizes rigorous application of ethnographic interviewing techniques including keeping structured field notes and analyzing the results using domain analysis (see Spradley 1979 and Bernard 1988 for example). RAP calls upon the researcher not only to identify how people categorize health information, but to constantly check and recheck this information with community members to refine it. RAP also seeks to explicitly identify emic versus etic perceptions of health⁵. Herman and Bentley (1993) also include tools in their

³ While RAP utilize similar tools, they are different than so-called participatory learning tools (RRA/PRA/PLA discussed below) that focus more on shared learning with community members.

⁴ The term extractive as used here and throughout should not be read as perjorative or as having a negative connotation. It is used to emphasize the way information is used and who uses it. In health communication approaches information is largely elicited and analyzed apart from community members (in a sense taken out of the community even if it comes back in another form as part of a communication strategy). In contrast, in the empowerment approaches discussed below, information is not collected apart from its immediate use by community members who use the information to make decisions and take action. In this sense information is not taken out of the community but fed back immediately to provoke discussion and make decisions. In addition, empowerment approaches have fewer pre-determined themes about which information is collected. Instead the research or learning process includes the identification of key health themes.

⁵ The opposition between ‘etic’ and ‘emic’ approaches to cultural analysis derives from linguistics, especially the work of Kenneth Pike (see Pike 1954). It is drawn from the distinction between phonetics and phonemics. Phonetics is concerned with the description of articulatory behavior as it can be detected by an observer, and with the classification of articulatory behavior in ways that can be applied to all languages and agreed upon by a scientific

home management of diarrhea RAP manual that are more commonly known as Rapid Rural Appraisal (RRA) tools (mapping for example). These tools engage participants a bit more in the analysis of their environment but is still done largely for the sake of the researcher who will use the information to design communication messages and methods.

One widely distributed tool for research and data collection by BCC and health communication professionals is “A Tool Box for Building Health Communication Capacity (1995), HealthCom, Communication for Child Survival Project.” While this Tool Box makes reference to adult education and the need to listen to people’s view, it still emphasizes mass media and the use of research to understand market segmentation and target audiences. This type of qualitative research emphasizes communication channels, target groups for a given communication activity, constraints to behavior change and adequate pre-testing of messages. Research yields information that is used by “outsiders” to develop health message strategies and especially to analyze the potential consumer of the health information. While behavior change is sought, the research results are not fed directly back to informants. It returns to them in the form of packaged messages.

Manoff has developed a technique they call Trials of Improved Practices (TIPS – Griffiths and Favin 1999) in which, after a brief period of research into the situation of households, they find a small number of mothers willing to try a new way of feeding or caring for a sick child. The changes are negotiated with individuals willing to try something new, and they are later visited to see how the experiment went. The experiment is accompanied by messages broadcast in the media or through interpersonal contacts that describe the benefits of changing behavior.

Critiques of Health Communication Approaches

Critical theorists from the empowerment approach view both conventional education with its emphasis on adding new knowledge and health communication with its emphasis on behavior change as incomplete views of learning which for them must include transformative learning through critical reflection of dilemmas. For example, Srinivasan (1992) asserts that behavioral change to reduce infant mortality should be achieved through critical analysis of options rather than persuasion using pre-selected solutions.

Literature reviews reveal deep unease and distrust of methodologies used in this approach such as applied behavior analysis and social marketing. For example, a conference report on behavior change in nutrition programs stated that some participants were ill at ease with the level of control of outside influences implied in behavioral change (Mason and Elliot 1995). Others question diffusion approaches intentional targeting of “opinion leaders” first. The assumption that these opinion leaders – who often represent elite groups – have clear communication with other groups may be faulty. Others fear that such an approach may simply reinforce the position of the powerful over the weak.

Social marketing’s theoretical base of consumer behavior and use of ideas and terms from the business world such as consumer, target audience, or product marketing are particularly distrusted. For example, Vanden Heeded and Pelican (1995) are wary of social marketing’s consumer orientation and urge nutrition educators to refer to people as learners, students, program partners or citizens rather than

community of observers. Phonemics, in contrast, is concerned with discovering those phonetic distinctions that are recognized as significant by the speakers of a language, and with classifying them so as to represent the patterns of a particular language. The ‘cross-language’ study of phonemics compares not articulatory events but the patterning of meaningful distinctions. The analogy to cultural analysis developed in anthropology during the 1960s with the so-called ‘new ethnography’. This approach revived the view of culture as cognitive processes and set itself the task of describing certain cultural domains (e.g. kinship, curing and ethnobotany) in terms of the patterns of meaning – the significant distinctions – in a particular culture (Silverman 1977).

consumers or clients. The principal drawbacks of this approach lie in its **dependence on subsidized products and on its lack of inquiry into what local populations may need** or how the product will be actually used. If people use condoms primarily for the five days following menstruation as was true in Sri Lanka (Nichter & Nichter 1987), the protection against pregnancy is quite limited. The classic model of social marketing does not include research into how purchased products might be used.

The BCC approach contains three assumptions about daily life that may not always accurately reflect conditions in developing nations. First, it assumes that individuals make decisions based on reasoned action, action engaged in after reflection on the costs and benefits of the action for the individual. This implies that the concept of self and **achievement is primarily individually defined** and understood, that individuals act mainly in their own interest. Second, it assumes that beliefs as articulated to outside interviewers are closely related to behavior, and may often determine that behavior. This conception states that people in developing nations often have beliefs about the causes of illness that are erroneous, that do not correspond to biomedical knowledge. A mother may rub traditional medicine on the head and palate of a dehydrated child rather than giving it fluids because she believes (erroneously) that the illness is caused by a spirit or some other phenomenon. Third, and most important, **the BCC approach always defines what elements are relevant to a problematic situation.** The experience of parents in treating their child for ARI or malaria is not relevant to understanding how treatment patterns may be improved. Parents must be brought to new understandings through effective messages and appropriate communication channels. The temptation to use biomedical criteria to define what is relevant, and to consider those criteria as qualitatively different from the experiences of parents, is simply too strong.

Taking local knowledge about illness and treatment options seriously without assuming that it is erroneous may be asking too much for public health specialists who have devoted their careers to improving the health status of mothers and children in developing nations. However, studies in medical anthropology have amply demonstrated that ethnomedical knowledge does not correspond to that of biomedicine, that mothers in developing nations have a rather different way of diagnosing diarrheal illnesses, for example (Yoder 1995), or the variety of illnesses that we classify as ARI. Thus the process of changing the response of parents to childhood illnesses is rather more complicated than finding the best messages to explain what should be done for a child with rapid breathing or blood in the stool.

Health Education for Empowerment Approaches

Health education for empowerment refers to **explicitly participatory approaches** that promote social responsibility and social justice and have an ultimate **goal of community empowerment.** While participation and empowerment have become ubiquitous and sometimes appropriated terms in health education, these educational approaches are differentiated from others in their distinctive use of certain theories and emphasis on societal values. In the academic world, these approaches are most often studied within departments of adult education.

The two subcomponents of education for empowerment selected here include Popular Education and Community Organization. Other, similar approaches used in international development health education settings include community development and social mobilization and will be referred to as necessary under the two subcomponents.

Popular Education Characteristics

Popular education is an alternative pedagogical movement that arose in Latin America in the 1960s and is heavily influenced by the Brazilian educator, Paulo Freire. Popular education explores **the dynamic relationship between knowledge, power and education.** This educational approach engages the poor in

individual and collective awareness of their problems and conditions; stresses a collective problem-solving approach; aims for social changes (Torres and Fischman 1994); and **explicitly addresses underlying structural problems or root causes** (Ewert 1989). Popular education has been most extensively applied in the field of literacy in countries such as Nicaragua.

*Situations in which Popular Education
Might be Appropriate*

- ◆ When the goal is to build critical self-discovery and action skills concerning health problems (in general) as opposed to a given (single) health issue.
- ◆ When health problems to be confronted are deeply rooted in broader social problems that people must come to “name” and confront – such as poverty, violence or low status of women.
- ◆ When complex skill development is necessary to overcome health problems.

Popular education is linked to resistance theory, cultural and social hegemony analyses and critical and feminist theories. Critical theory incorporates various elements of social learning, behavioral, cognitive and humanist traditions of learning but is distinct in the attention to **critical reflection as a key element of learning**. Critical reflection involves the identification and evaluation of assumptions, beliefs and values that underlie a person’s thoughts, feelings and actions. It goes beyond the subject matter knowledge because it relates learning to values, philosophy, worldview and the nature of knowledge itself. Critical theorists distinguish between instrumental learning (the process of learning to control and manipulate the environment or other people); communicative or dialogic learning

(understanding the meaning of what others communicate); and transformative learning (using critical reflection of anomalies or dilemmas) to bring about perspective transformation. **Thus, learning involves not only adding new knowledge or changing behavior but also transforming underlying assumptions of how the world works** (Deshler and Kiely 1995).

Paulo Freire’s educational philosophy as described in his book “Pedagogy of the Oppressed” is set within a larger framework of radical social change viewed as a necessary corollary to critical reflection. Freire (1996) states that education is never neutral as it either oppresses or liberates. The oppressor’s interests lie in changing the consciousness of the oppressed, not the situation which oppresses them while liberating education involves the action and reflection of men and women upon their world in order to transform it.

Freire distinguishes between **banking education, where knowledge is deposited like money into student receptacles, and problem-posing education, where teachers and students cooperate in a dialogue**. Banking education treats students as objects of assistance whereas problem-posing education transforms them into critical thinkers through inquiry and true reflection and action on reality.

Other key concepts in Freire’s work include praxis (a spiral of action and reflection by men and women upon their world in order to transform it); conscientization (a process of problem analysis, self-awareness and self-reflection by which men and women achieve a deepening awareness of the sociocultural reality that shapes their lives and their capacity to transform it); and dialogue (interaction between students and teachers requiring humility, faith in humankind, hope, love, commitment and critical thinking). Anti-dialogical forms of action include a focalized or isolated view of problems, manipulation and cultural invasion. In cultural invasion, the invader may assume the role of a helping friend or desire to know how those they invade apprehend reality but only so that they can dominate more effectively. In contrast, cultural synthesis involves actors who come from one world to another, not to teach or transmit, but rather to learn with people (Freire 1996).

See Case Study 5: Child Survival and Development Program, Iringa, Tanzania, on page 31. This program draws extensively from critical theory and Freirian concepts related to popular education.

Some popular educators such as Vella (1995) and Hope and Timmler (1984) incorporate humanist theory. Humanist educational theorists promote personal growth and self-actualization of learners. Maslow describes how human beings, after meeting their basic needs, will then strive to fulfill their self-actualization needs (or reach their potential) through learning. Malcolm Knowles' concept of andragogy describes the art and science of helping adults learn. Andragogy strives to identify the unique goals of learners, use personal experiences as a resource for learning, and ensure supportive interpersonal climates. Here, teachers are perceived as facilitators in a learner-centered environment. Humanists often develop needs-based educational programs; use group discussion; encounter group methods; and experiential learning (Deshler and Kiely 1995). In the humanist tradition, **knowing is a complex process involving the entire or whole person and is physical, affective and cognitive** (Vella 1995).

Popular education's key educational methodologies involve co-investigation of generative themes or the vital issues of a group or community. These generative themes are translated by facilitators into "codes" which may be a representational picture or description of a situation. Codes are different from messages in that they pose an "open-ended problem." These codes are then presented to learners in problem-posing sessions where carefully selected open questions lead learners and facilitators through analysis of the situation; how it applies to the group's experiences and a discussion on what can be done (Hope and Timmel 1984). Popular education draws on people's own art forms which may include theater, dance, storytelling, music, songs, poetry and art to stimulate reflection and analysis (Ewert 1989). Aubel et al. (1992) describe a diarrheal disease control program in Niger where Freirian codes were developed with Hausa villagers based on simultaneous consideration of community beliefs and national program priorities around diarrheal disease.

Popular education explicitly links analysis with action; personal experiences with social structures; and local experience with historical and global processes. An AIDS prevention project in Haiti, for example, helped rural women to produce a video on AIDS which linked vulnerability to HIV infection with broader issues of peasants' access to land, political problems and male/female power relationships (Stetson and Narcisse-Prudent 1994).

In popular education the transformation of power relations in societies begins with the relationship between teacher and learners through modeling of democratic relations in the learning experience. Everyone teaches, everyone learns, everyone investigates and respect for learners is emphasized (Farlow 1987; Arnold et al. 1991). Werner and Bower's (1982) manual entitled "Helping Health Workers Learn" exemplifies this teacher/student dialogue in health worker training settings with their emphasis on relations of mutual respect between trainers and health workers.

Popular education requires highly skilled animators, and there is a considerable time investment in their community work.

Community Organization Characteristics

Popular education is linked to community organization because it strengthens the ability to organize and is an ongoing process not limited to a workshop (Farlow 1987; Arnold et al. 1991). Minkler (1990) defines community organization as **a process by which community groups are helped to identify common problems or goals; mobilize resources; and develop and implement strategies for reaching these goals.** Implicit in this definition is the concept of empowerment or the enabling process through which individuals or communities take control over their lives and their environments (Minkler 1990).

The term community development is sometimes used interchangeably with community organization and has virtually the same definition in some adult education literature. However, community organization reflects explicit links with a more radical social change process such as that developed by Saul Alinsky. Another very close term is that of **social mobilization.** Social mobilization was coined by UNICEF to describe their strategy used to involve actors at many levels – including communities - in a process of

developing, planning, implementing and evaluating programs of common concern (UNICEF 1993). While community organization and popular education have very close conceptual and theoretical links, **community organization more explicitly refers to work with groups in a particular geographic community**, is sometimes perceived as seeking more to reform than to transform, and is perceived to be somewhat more pragmatic (Hamilton and Cunningham 1989).

Key concepts in community organization practice include

- empowerment (enabling process through which individuals or communities take control over their lives and environment)
- community competence (stimulating people to think critically, identify problems and new solutions)
- participation
- community-identified issue selection
- Freirian notions of critical consciousness
- group-planned action for transformation of the situation (Minkler 1990).

Situations in which Community Organization Might be Appropriate

- ◆ When the solution must be community driven – as in care for people with HIV/AIDS or emergency evacuation plans for obstetric emergencies.
- ◆ When systemic barriers such as when lack of resources and access, or restrictive laws or practices must be overcome.
- ◆ When broad social change is necessary - as opposed to altering certain local power relationships.

Community organizing within the United States began with 19th century social workers engaged with immigrant and poor populations. Work with poor and oppressed groups in the 1950s by activists such as Saul Alinsky shaped community organization and the field led to movements such as the civil rights movement. Internationally, within the field of health, the importance of community organization was formally recognized by the International Conference on Primary Health Care in Alma Ata and has been articulated by WHO, UNICEF and other international bodies.

Teachers in community organization are called animators and are trained in conscientization techniques. Animators work alongside community members to promote dialogue, interaction, conflict resolution and problem solving within a community (UNICEF 1993). Community organization stresses community capacity-building. For example, UNICEF’s social mobilization project in Iringa, Tanzania

sought to reduce infant malnutrition and mortality through capacity strengthening of villagers, mothers and politicians to analyze and assess nutritional problems and causes and take appropriate actions. Attention to root causes was encouraged through use of UNICEF’s conceptual framework showing symptoms, immediate, underlying and basic causes of malnutrition (UNICEF 1993).

While there are fewer examples of health education programs using this approach compared to health communication programs, UNICEF’s program of social mobilization in Iringa, Tanzania was considered to be cost-effective. This was because the communities provided a substantial portion of the operating costs; recurrent costs were restricted primarily to drug kits and vehicle amortization; and the cost of sustaining the program was estimated at US \$3-\$5 per child per year. The investment of time in the project was considerable and felt to be crucial in achieving the social mobilization process objectives (UNICEF 1993).

See Case Study 6: NGO Coalition for the Prevention of HIV/AIDS on page 33. This project illustrates a community education approach to health education.

Research and Data Collection Methodologies used in Empowerment Education Approaches

Participatory research is a related field to popular education that has grown out of adult education practice in southern countries and is a process combining research, education and action. It is a means of **putting**

research capabilities into the hands of poor and oppressed people and is considered profoundly pedagogical in the sense of learning through searching and researching. People are in charge both of knowledge production and knowledge utilization. Participatory research strives to democratize practice and promote transformative relationships in inquiry or research settings. It places an enormous emphasis on recovering suppressed local knowledge (Park et al. 1993).

Participatory action research is another process similar to popular education and emphasizes endogenous consciousness-raising through knowledge generation (Fals-Borda and Rahman 1991). Participatory Rural Appraisal (PRA) is yet another stream of this type of research and defined as a family of approaches and methods to enable rural people to share, enhance and analyze their knowledge of life and conditions in order to plan and act which stresses self-critical awareness and commitment to the poor, weak and vulnerable (Chambers 1997). While PRA is indistinguishable from RRA in terms of the tools used, it differs from RRA in how information is used. In RRA **learning from** the community is the key. In PRA information is used to plan and to act. Learning necessarily leads to action (Pretty et al, 1995).

In general, these approaches view research as inseparable from health education and indeed an actual part of it. Information is not extracted but is generated and analyzed punctually, in a participatory way by outsiders and community members. The outsider is no longer a researcher – though he or she may still rely largely on applied anthropology techniques such as semi-structured interviews and observations –but acts as a problem poser or catalyst. The research techniques often go beyond interviewing to include tools which involved psychomotor (physical manipulation of information) and affective (invoking an emotional response) elements as well as cognitive ones. The goal of these tools is to not only generate information but also to promote the inspection and analysis of it by those who are generating it. The outsider/facilitator may then use this information and his/her own knowledge of technical content to negotiate or propose actions by participants. In this sense, the information is owned by all participants and health education is part of a seamless flow of information between facilitator and participant.

Critiques of Empowerment Education Approaches

Health communicators have not critiqued empowerment approaches in the same consistent way as conventional education, although Braun et al. (1994) write that community participation and mobilization models do not represent a complete model needed for health communication. Rather, some health communication proponents have appropriated the discourse of empowerment education, citing the participatory nature of their methodologies. For example, Lefebvre et al. (1995) claim that social marketing is a method of empowering people to be totally involved and responsible for their well-being as well as a comprehensive strategy for effecting social change because of the continual dialogue with consumers.

A number of empowerment educators themselves have highlighted weaknesses in their approach. Chief among these are the time and resource investments necessary to train animators in problem-posing educational methodologies. This is a long (and likely) costly process because animators have been so thoroughly socialized in “banking” education approaches. Popular educators Hope and Timmel (1984) describe major problems training animators as they tended to slip back to using old, authoritarian methods. In addition, some practitioners feel that these approaches demand a great deal in terms of participants’ time and the tendency to overemphasize **the analysis of root causes is unethical because it results in neglect of short-term solutions to lessen suffering.** In Haiti, health program managers in an AIDS prevention project were challenged by one colleague to recognize their failure in distinguishing root causes of HIV infection. One medical doctor responded wearily that while he recognized this, he still had to “get up in the morning and do something practical.” Gender analysis has revealed that community organization approaches have not always adequately differentiated subgroups such as women within communities, leading to situations where the “oppressed” are in turn “oppressors.” Lastly, in settings where the social or political environment is repressive, popular education approaches in health or

other programs may be perceived as too threatening to authorities in power.

Analysis of Inherent Tensions (Contrasts) among Health Education Approaches

The foregoing description of the various health education approaches, and especially the critiques of each approach demonstrate some *inherent* tensions that exist among the approaches. “*Inherent tensions*” is emphasized because, to date, there seems to have been little debate or discussion among proponents of different views. However the **tensions or contrasts** exist and are apparent in at least three areas:

- 1) the varying emphases of the approaches concerning **participation**
- 2) the way in which **health problems are defined**
- 3) the values of each approach in terms of **preferred actions to be taken**

Participation

Participation has become a ubiquitous term in international development and the field of health education is no exception. NGO health education programs representing all three health education approaches described in this paper usually claim to be participatory in some way. Thus, the interpretation of what the concept of participation involves or means is important to illuminate why tensions exist between proponents of the different health education approaches.

Deshler and Sock (1985), through a review of participation in international development work, devised a ladder of participatory control. At the bottom of the ladder is “pseudo-participation” which is domesticating and paternalistic in nature and where participation is conceived as manipulation, therapy, informing, consultation and placation. At the top of the ladder is genuine participation which involves cooperation and empowerment where participation is conceived of as partnership, delegated power and citizen control.⁶ Oakley (1989) writing specifically on participation and health programs, distinguishes two different interpretations of participation which represent two ends of a continuum: **participation as a means and participation as an end.**

In the first interpretation, participation is seen as a means of achieving set objectives or goals. Here participation is a way of using economic and social resources of rural people to achieve pre-determined targets. The results of participation are thus more important than the act of participation. Nevertheless, the results may indeed lead to a welcome improvement in the environment of rural people and may well coincide with local needs as perceived by these people. In this interpretation, participation may be seen as a means to improve the efficiency of service-delivery systems. Participation as a means is essentially a static and passive form of participation, a temporary feature or input required if objectives are to be achieved. In the second interpretation, participation is regarded as an end in itself, a process whereby confidence and solidarity among rural people are built up. Two critical elements of the process are awareness raising and capacity-building of organizations. The process is usually dynamic, unquantifiable and unpredictable as it is created and molded by participants. Participation as an end is active, responding to local needs and changing circumstances; lasting beyond the life of the project (Oakley 1989).

Didactic health education activities are not concerned with participation because teachers are traditionally taught to lecture and give orders (Shor 1992). While social marketing involves people in testing out the product or message, Srinivasan (1992) argues that it is the ultimate purpose of participatory methods that

⁶ Pretty et al (1995) provide a similar seven-part typology of participation which goes from passive participation to self mobilization. Their use of self mobilization is similar to Rifken et al. (1988) definition of participation: *Community participation is a social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet those needs* (p933).

counts. She acknowledges that social marketing may be considered participatory in that it tries very hard to learn more about the target audience, but that **the ultimate purpose of participation in social marketing is to defuse objections before they arise in order to better persuade people to adopt a behavior** (Srinivasan 1992). **Health communication approaches consider participatory processes more as a means to an end** as described by Oakley (1989) above. The involvement of community level social networks, community groups in a health communication project is viewed by health communication proponents as a means to maintain appropriate health practices in mothers and caretakers over the long-term (Graeff, Elder and Booth 1993) to ensure the “end” or the achievement of health objectives and goals such as reducing infant morbidity and mortality. Colle (1993) who is a health communication expert, agrees that involving people in the design of messages to be disseminated is not participatory because participation is not the ultimate goal. He cautions against an ideology of participation and defends communication approaches that address questions of the greater good, scale and rapid response (Colle 1993). Empowerment approaches consider processes such as capacity building, community organization, and transformative learning as goals to be pursued simultaneously with health objectives. **For example, an empowerment approach gives equal emphasis to technical health care training and training in community development processes** (Oakley 1989).

Definition of Health Problems

Just as the definition of participation differentiates the health education approaches and partially explains the tensions among their proponents, the way in which health problems and solutions are articulated in a particular health education approach need to be understood. For example, does problem analysis emphasize individual or larger societal forces? Should the immediate and/or root causes of the problem be addressed?

The conventional health education approach conceives of health problems in a rather narrow and superficial manner: **individuals have a knowledge deficit** and need expert information. Health communication and social marketing approaches focus on problem analysis that emphasizes individual, community or organizational behavior change. **Poor health is due to incorrect practices and behaviors** (such as not taking children to be immunized or incorrectly treating diarrheal disease) at these various levels.

Questions for Analysis and Reflection

- 1. What are your assumptions-about the local population (their knowledge and practices)-that will influence the way you develop the health education intervention?**
 - ◆ What is driving poor health in this population?
 - ◆ How can these issues be dealt with via a health education intervention?
 - ◆ What does the population understand about these causes of poor health?
 - ◆ What information does the population have concerning health issues that is important to understand?
 - ◆ From where do the solutions to be applied to improve health outcomes come-who decides?
 - ◆ What other information do you lack concerning health problems and how can you fill these holes?
 - ◆ What is the role of your agency/group in the education intervention?
 - ◆ Who else has a role in the intervention and what is that role?

- 2. What are the social processes that you are seeking to create or promote?**
 - ◆ Who, in the population, will the “learners” be?
 - ◆ What types of interactions does your intervention envisage carrying out with these learners?
 - ◆ Who are the “teachers” in the intervention?
 - ◆ What are the roles of the teachers and learners in this intervention?
 - ◆ Who else must be involved in this intervention for it to succeed?
 - ◆ What should be happening in the population as a result of this intervention?
 - ◆ What changes will occur in the population as a result of this intervention?
 - ◆ What will you do to promote these changes?

Empowerment education approaches conceive health problems in terms of **resource inequities and oppression**. An unequal distribution of economic and sociopolitical power may be seen as the cause of poverty and disease. People and communities are unable to address health problems because of their lack of critical awareness.

Values – “Remedy” or Action to be Taken

Values refer to preferences for courses of action and outcomes. Thus, the values associated with a particular health education approach shape choices among alternative actions. Worldview refers to the set of beliefs that explain the world and also suggest desirable activities (Brown and Tandon 1983).

The **didactic approach** implicitly supports existing power and divisions in society by appearing to be neutral (Shor 1992). The **health communication approach** assumes that societies have common interests and consensus in solving problems of public health. The centrality of individuals is important in health communication as well as efficient and effective task accomplishment. **Empowerment health educators** view societies as potentially conflictual and emphasize fundamental differences of interests among social groups. They tend to analyze problems in terms of community and social structures. These differences in values and worldviews shape the range of decisions on educational and research methodologies such as the nature of participation required; the individuals or groups to be reached; or the methods of education or communication to be used (Brown and Tandon 1983).

While recognition of poor health status is shared among all health education approaches, their different values and worldview produce different perspectives on just how health education can address this situation.

The matrix on the following page summarizes the characteristics of each approach described above. It includes an analysis of the critiques made of each approach and should serve as a useful reference for readers as they analyze their own health programs. In addition, readers are encouraged to use the **“Questions for Analysis and Reflection”** included here to:

- 1) analyze their assumptions about “learners” and “teachers” and the health education process
- 2) critically examine approaches they are using (or planning to use) based on these assumptions
- 3) consider the social process they are seeking to create at the community level (or beyond)
- 4) examine the resources necessary to implement and sustain activities for health education activities they are implementing or planning.

Questions for Analysis and Reflection

- 3. What are the resources that you will make available to the population via the intervention?**
 - ◆ What are the different kinds of resources will you be offering to the population in this intervention?
 - ◆ What resources will “remain” in the population after you are gone?
 - ◆ Based on what you will do to promote change, what training or capacity-building is necessary?
 - ◆ What kinds of research/learning are necessary to accomplish the intervention and what resources will they require?
 - ◆ What human resource development – if any – is necessary at the population level?
 - ◆ Given what you determined about the teacher and learner above, what investments will be made on behalf of each?
 - ◆ What kinds of ongoing investment will be necessary to continue actions/processes begun during the intervention?
- 4. In what ways is your intervention sustainable beyond the life of the “project”?**
 - ◆ What will make this intervention sustainable – the minimum set of conditions necessary?
 - ◆ Who will be responsible for assuring that this occurs?
 - ◆ What must you do during the intervention to assure the sustainability you seek?
 - ◆ What parts of the intervention are not expected to “continue” and how important are they to the continuation of key actions/activities?
 - ◆ How will you know whether the intervention has reached the minimum set of conditions?

	Conventional Health Education	Health Communication		Empowerment Health Education	
		Social Marketing	Behavior Change Communication	Popular Education	Community Organization
Worldview (assumptions about education, “teacher” and learner)	<ul style="list-style-type: none"> Poor health is caused by lack of knowledge or ignorance. Teachers are experts or facilitators who create conditions to facilitate cognitive learning. Learners lack knowledge. Knowledge leads to action 	<ul style="list-style-type: none"> Poor health is due to a lack of optimal innovations/practices. Adequate knowledge leads to voluntary adoption of practices. Experts make decisions after consulting consumers to better craft messages. 	<ul style="list-style-type: none"> Poor health is due to poor behavioral practices. Adequate knowledge – adapted to real needs – leads to improved behaviors. Learners are target audiences consulted by health experts 	<ul style="list-style-type: none"> Poor health due to lack of critical reflection skills of individuals and oppression. Power relations must be transformed. “Teacher” is a problem poser. Learner is subject who must reflect/act for change to occur 	<ul style="list-style-type: none"> Poor health due to lack of community control over environment. Reformation of society is necessary. Animators raise consciousness and build capacity among community members.
“Remedy” (action to be taken)	Provision of information	Diffusion of messages crafted to attract and motivate the population	Dissemination of messages that account for population needs	Facilitation of critical reflection process that leads to action and further reflection	Mobilization of community members (along with others outside the community) to identify common problems and develop strategies to overcome them
Theoretical Base	Intuitive use of previous experience in formal education settings	<ul style="list-style-type: none"> Marketing theory Consumer behavior Diffusion of innovations 	<ul style="list-style-type: none"> Applied Behavior analysis Social Learning (Cognitive) Theory Health Belief Model 	<ul style="list-style-type: none"> Critical theory Freirian concepts Humanist adult education 	Saul Alinsky’s social change processes
Historical Roots	Traditional mode of learning in formal education systems.	Marketing theory from business world was applied as social marketing to health field in 1980s in developing countries.	USAID-supported development communication as applied over past 25 years in developing countries.	Paulo Freire’s work in Latin America first used in field of literacy training.	<ul style="list-style-type: none"> 19th century US social work in poor communities. International primary health care movement (Alma Ata) in 1970s.
Education Methodologies (interaction that takes place with the population)	<ul style="list-style-type: none"> Didactic methods include: rote learning, lectures Cognitive methods include: concept mapping, use of metaphors, analogies and similes, organizing strategies. 	<ul style="list-style-type: none"> General content predetermined Research with population done to anticipate objections Messages delivered through communication channels (often mass media) to promote specific behaviors. 	<ul style="list-style-type: none"> General content predetermined. Message development done via research to learn what people need and can/can’t “do”. Communication channels vary and are selected based on research. 	<ul style="list-style-type: none"> Problem-posing education. Co-investigation of generative themes. Open-ended dramas/critical incidents/projective stories. Critical examination of personal experiences often in support groups. 	<ul style="list-style-type: none"> Community dialogue, conflict resolution and problem solving. Capacity building. Action planning.
Resources Required	Minimal because educational content is pre-determined.	High to accomplish complex research process (audience segmentation etc.) but seen as efficient by proponents in delivering results.		<ul style="list-style-type: none"> UNICEF’s experience with social mobilization proved cost-effective in Tanzania setting. Examples lacking but human resource needs (well trained facilitators and organizers) are considered high. 	
Research/Data Collection Approach	Baseline studies and tests used to determine is content assimilated as taught.	Thorough situation analysis, consumer (focus group) and market research, formative evaluation and demographic analysis.	<ul style="list-style-type: none"> Ongoing systematic research to fine tune communication strategies. Epidemiological findings accompanied by qualitative research including RAP. 	Research is part of education as means for critical analysis. Often referred to as Participatory Learning and Action (PLA) to emphasize the need to act on what is learned.	
Critiques	<ul style="list-style-type: none"> Top down, non-participatory Reinforces oppressed people’s dependency on outsiders. Overly focused on individuals and their intellectual feelings. Bias towards interpersonal communication. 	<ul style="list-style-type: none"> Manipulative, too controlling by outsiders. Distrust of marketing/ consumer orientation. Diffusion focus on “opinion-leaders” problematic 	<ul style="list-style-type: none"> Though consultative, not empowering. Focus on problem-solving and critical reflection by population limited or absent 	<ul style="list-style-type: none"> Inattention to short-term needs of population. Highly skilled animators need considerable training and tend to slip back into old authoritarian methods 	<ul style="list-style-type: none"> Though participation is key, approaches often do not adequately differentiate subgroups (especially women) and their needs. Requires substantial time commitment by population.

CASE STUDIES

The following case studies are presented in order to illustrate ways in which various health education approaches have been applied in field settings. Each study contains the following elements:

- Educational Approach(es) Illustrated
- Description of the Program
- Specific Activities including
 - Research and Data Collection Methodologies
 - Education Methodologies and Theoretical Base
- Worldview and Level of Participation
- Resources used to Develop the Case Study

Several of the case studies **draw from more than one health education approach**. Is this “eclectic” approach good or bad? Is it purposeful or perhaps more haphazard? It should be remembered that **different health education approaches sometimes use the same methodologies or theories**. For example, social learning theory may be used both within health communication and health empowerment approaches, the difference being that health empowerment approaches would always include critical reflection alongside social learning theory. Also, use of several health education approaches may reflect a thoughtful and purposeful intention of an NGO to address both short-term “practical” needs alongside longer-term “strategic” issues, an approach advocated within some gender and development programs. While practical application of different educational approaches is not an absolute “either/or” choice, **project managers should be aware of the possible pitfalls or contradictions in doing so**.

First, a methodological “mix” risks **diluting the level or quality of participation** envisioned by many health education project managers. The purpose of social marketing for example, is to convince or persuade people to do something, in the case of behavior change communication, to practice a certain behavior. This would appear to be antithetical to an empowerment educational approach, whereby people should decide to practice a certain behavior after their own critical analysis of options.

Second, a methodological mix sometimes results in resources and skills being put into one approach with only “**lip service**” **paid to methodologies** coming from a second approach. An example of this comes from the case study on the RICHES Project (see below) where a BCC-focused program put in place community committees to increase community participation. These community committees floundered and were largely dysfunctional by the end of the first phase of the project. New RICHES program managers with more knowledge of community organization revised the project’s strategies to honor local definitions of “community” and encourage dialogue among community members around health issues and education. This resulted in dramatically improved participation by community members in RICHES. This illustrates how organization of community committees requires in depth knowledge of community organizational processes, training content, and knowledge of community dynamics. Taking a piecemeal idea (such as community committees) from a community organizational approach without taking into consideration the entire approach may give poor results.

Third, in the end, **one set of values or worldview will ultimately prevail** in the health education approach, even if it is implicit. This is because one’s worldview or values affects the analysis of problems and ultimately “drives” the solutions to be found. Recall the example from Haiti described in the box on page 3.

Case Study 1: Condom Social Marketing

Educational Approaches Illustrated

Population Services International (PSI), a private, nonprofit social marketing organization, has wide experience in social marketing of condoms to prevent HIV/AIDS. Most condom social marketing (CSM) projects include activities to make condoms affordable, available and attractive. CSM projects have dramatically increased the acceptability of condoms through advertising and marketing techniques in countries in Africa, Latin America and the Caribbean.

Description of the CSM Project

The CSM programs in all of these countries aim to make condoms 1) affordable by selling them at subsidized prices so that many people can purchase them; 2) available by marketing them through thousands of outlets in a country including nontraditional outlets; and 3) attractive by creating an image using brand names, logos and sophisticated packaging and promotion.

For example in Haiti, PSI worked with a local pharmaceutical distributor called DOBACO to launch Pante (Panther) brand condoms as part of a social marketing AIDS prevention effort. Sales of Pante condoms went from 30,000 per month in 1992 to a high of 600,000 in January 1994. By March 1995 more than 8 million Pante condoms were sold in Haiti.

Like other CSM projects in Africa, the Haiti project combined an aggressive marketing strategy with a creative communication campaign. PSI and DOBACA worked through private sector distribution channels such as nightclubs, beauty parlors, lottery kiosks and market stalls. A Haitian advertising firm, ARCA developed the communication campaign using billboard, TV and radio ads and developing a rap song.

Educational Approach

Education Methodologies and Theoretical Base

The PSI CSM project exemplifies the use of consumer theories. Sexually-active individuals are persuaded to purchase condoms such as Pante in Haiti through the optimal marketing mix of attention to product, price of the product, the place where the product moves to users and promotion such as advertising. Pante condoms are attractively packaged; cost 7 US cents for a three pack which is 50% lower than the leading market brand in Haiti; are sold through 1,200 traditional and non-traditional outlets throughout the country and are now a household word due to the communications campaign which capitalized on Haiti's love of soccer with the slogan "Don't take a hit". Use of mass media in Haiti such as billboards, TV and radio spots typifies social marketing's reliance on this communication channel as one that extends the reach of messages and carries a special authority.

Audience segmentation is illustrated in Haiti by a 1995 initiative to promote condom use among women. Under an initiative entitled Women's Protection, PSI has recruited women sales agents who act as peer counselors, teaching women how to negotiate condom use with men. Advertisements and promotional calendars portrayed women in an attempt to destigmatize condom use among Haiti's sexually active population.

A wide variety of sales outlets for condoms are viewed as opportunities to teach people why and how to use condoms. Pamphlets and brochures are often available at sales points and at some outlets, health

educators demonstrated correct condom use and encouraged safer sex behavior. Spontaneous discussions about condoms and HIV/AIDS often breaks out among shoppers viewing a sales display. In addition, increased sales outlets are seen as a means to sensitize individuals to condoms.

The barrage of outlets and messages through mass media are seen as a means to get the message across that condoms are part of everyday life and should be seen as an everyday means of saving one's life.

Worldview and Participation

The condom social marketing program implemented by PSI in countries such as Haiti focus clearly on the goals of increasing acceptability of practices that are beneficial to public health. The CSM proponents write that in the absence of a cure or vaccine for HIV/AIDS prevention, the consistent and correct use of latex condoms is the key to slowing the pandemic. CSM thus focuses on dramatically increasing the use of condoms on a nationwide basis and cites achievements such as increasing yearly distribution and selling of condoms in the former Zaire from 300,000 to 18 million. The educational focus is on people as consumers and education as persuasive advertising, particularly important to CSM proponents as a means of desensitizing condom use which is a highly sensitive topic in Africa as elsewhere.

Participation of people in CSM programs is tied to development of the product and finding the most persuasive messages. CSM proponents highlight the greater public good of their intervention (such as preventing 7,200 potential HIV infections in one year in the former Zaire through social marketing of condoms).

Case Study Resources

Frank, R.A. (1995). "The Private Sector and Condom Distribution: We Can Do More." *AIDSCaptions*. Vol. II, No. 1, March 95, pages 10-13.

Dadian, M.J. 1996. "Casting a Wider Net: Improving Access to Condoms" *AIDSCaptions*. Vol. III, No 2, July 96, pages 21-23.

Case Study 2: Hearth Program

Educational Approaches Illustrated

Hearth programs illustrate the move in nutrition education from a conventional education approach for nutritional rehabilitation of children to one which **straddles behavior change communication (drawing heavily on social learning theory) and empowerment education**, in particular through the use of a "social deviant" research methodology where learners are highly involved. However, the Hearth program's main objectives and emphasis on behavioral change are more congruent with those of a health communication approach.

Description of the Hearth Program

Hearth programs engage parents in rehabilitating their malnourished children at home using diets based on local knowledge and resources, and to sustain enhanced nutritional status after rehabilitation. A secondary objective is the establishment of community structures (such as volunteer mothers networks or local leaders) to contribute to improved primary health care in communities. Hearth programs take place in the context of larger nutrition programs that include growth monitoring, micronutrient supplementation, deworming and treatment for infectious diseases.

“Hearths” are two-week interventions where volunteer or minimally compensated community members, sometimes called *animatrices*, work with caretakers⁷ to feed malnourished children one calorie-dense meal each day in addition to their normal diets. These feeding sessions are sometimes accompanied by educational sessions where basic nutrition and hygiene are taught to mothers. The feeding and educational sessions take place within village or community settings, usually next to a mother’s kitchen area or “hearth”.

Participating children usually gain weight, presumably because their parents adopt and continue feeding practices learned in the two-week program. Children who do not gain weight due to underlying illnesses are referred to a medical center. In two programs, a revolving loan fund was instituted for families unable to nutritionally rehabilitate their children after participating in the Hearth to provide additional food and revenue resources.

The Hearth program has historical roots in nutrition rehabilitation centers, implemented in many developing countries in the 1960s. These centers, while having some positive impact, experienced problems in their high recurrent costs, slowness in reaching eligible children and failure to reach the poorest eligible beneficiaries. These nutrition rehabilitation centers typically included a conventional educational approach where mothers received structured teaching or even “preaching” on health topics. In contrast, the Hearth program represented a smaller, faster, targeted and less expensive approach to nutrition rehabilitation. Hearth’s educational approach emphasizes learning by discovery and doing. Versions of the Hearth program have been implemented by Save the Children, the Albert Schweitzer Hospital and World Relief in Haiti, Vietnam and Bangladesh. Drs. Warren and Gretchen Berggren were instrumental in the development of Hearth programs in all of these settings.

The behavior change aspects of the Hearth program have been carefully evaluated and preliminary results and analysis in the various program sites show reduction of overall malnutrition, prevention of deterioration of mildly malnourished children and high rates of catch-up or adequate growth in participating children. In addition, affordable program costs allow potential replication. In one site a network of health volunteers was sustained and in another community committees volunteer services and track results of growth monitoring and promotion activities.

Educational Approach

Research and Data Collection Methodologies

Prior to the development of the calorie-dense supplementary meal, *animatrices* and Hearth staff members identify positive deviant families within the community (poor families with well-nourished children) by using the existing health information system and family registration. These families’ feeding practices are identified through diet recall interviews. A market exercise is then undertaken by the *animatrices* where they must buy the identified foods with a limited budget equivalent to what households actually have access to. This research results in the identification of Hearth menus using readily available, low-cost or free foods. Hearth program designers view this type of research as part and parcel of their educational strategy. *Animatrices* who are involved in these studies become convinced that they can afford to feed this food to the children within the communities they serve. In fact, in Haiti where repeated positive deviant and market studies in different areas gave the same menu, Hearth staff continued the exercises because of their educational value.

⁷ In most cases, caretakers participating in Hearth programs are the child’s mother and the term mother will be used in the rest of the text.

A series of preliminary community meetings is held prior to Hearth implementation to explain the purpose, methodology and requirements of the Hearth program. Data from the health information system (such as pie charts of children's nutritional status) is used during these meetings to garner community support of the Hearth intervention and to convince the whole community that a malnutrition problem exists.

These types of research activities **illustrate empowerment education approaches** where participatory learning techniques are used to enable rural people to share, enhance and analyze their knowledge of life and conditions in order to plan and act.

Education Methodologies and Theoretical Base

The educational aspects of the two-week Hearth program around nutritious foods and feeding practices feeding (which emphasize food types and feeding behaviors) illustrate applications of theories often used in behavior change communication: **applied behavior analysis and social learning theory**. Hearth's education approach focuses on the daily behavior of mothers in feeding their children rather than conveying knowledge of nutrition. It is the transformation of a passive, crying, malnourished child into an alert, active and happy child which provides a powerful reinforcement for the mother to practice new feeding habits, rather than transfer of knowledge. Behavioral reinforcement is also undertaken through activities such as required daily handwashing.

Hearth is a very clear illustration of **social learning theory's view** that learning is primarily a social process where people learn through observations and interactions in a social context. Potential disincentives to changing behavior within a community such as lack of peer support are mitigated by social support during the Hearth sessions and afterwards through home visits by the *animatrices*. **Social learning theorists' emphasis on learner capacities** is also incorporated into Hearth programs. Learners receive knowledge and skills to perform new feeding behaviors through the two-week experience of buying low-cost foods and cooking nourishing meals. Mothers also learn through observation in that they are taught by a model, the *animatrice* in this case, who demonstrates the desired behavior. The mothers are able to anticipate a positive outcome (expectation) through the success of the positive deviant mother. Finally, mothers increase their self-efficacy or confidence in performance of a behavior through the daily repetitions of feeding new foods.

Worldview and Participation

Hearth program designers state that while programs attacking root causes of childhood malnutrition may show impact, this will only occur in the long term. Hearth is thus clearly perceived by its proponents as an interim intervention with immediate results and is congruent with behavior change communication's worldview that better health is dependent on changed behavioral practices of individuals and its focus on health behaviors.

Hearth programs do **cross over into empowerment health education approaches, particularly through the emphasis on local knowledge in its positive deviant research methodology and the feedback to the community through meetings where malnutrition status is discussed**. However, Hearth program interventions and outcomes focus on more effective coping skills taking the particular environment as a given rather than other interventions leading to transformation of power relations or underlying root causes which contribute to child malnutrition. The concept of **participation** in Hearth is framed primarily in terms of **community consultation** to support the Hearth intervention and its wider primary health care program. Individual participant participation is viewed as a means to increase the efficacy of the educational intervention.

Case Study Resources

Information on this case study comes primarily from the following document as well as personal knowledge of one of the authors who implemented nutrition foyers, an earlier version of Hearth programs, in Haiti.

Wollinka, O., E. Kelley, B.R. Burkhalter, N. Bashir, (eds.) (1997) *Hearth Nutrition Model: Applications in Haiti, Vietnam and Bangladesh*. Published for USAID and World Relief Corporation by the Basic Support for Institutionalizing Child Survival (BASICS) project. Arlington, VA.

Case Study 3: RICHES Project

Educational Approaches Illustrated

The RICHES project illustrates a **behavior change communication educational approach** emphasizing message delivery through interpersonal communication to teach rural Haitian women health and nutrition topics. The RICHES health education curriculum was developed using applied anthropological methodologies and is a strong example of the use of Rapid Assessment Procedure (RAP) techniques to develop culturally-appropriate messages. These messages, in the form of songs, skits, proverbs and riddles were transferred to women through face-to-face communication channels.

Description of the RICHES Project

The RICHES program was implemented by CARE in rural Haiti starting in 1988. The program was a community-based approach to delivery of maternal-child health services in areas with limited access to medical services. RICHES replaced an earlier MCH program which had used food aid for nutritional supplementation and where education was undertaken by nurse-auxiliaries. In contrast to the earlier program, RICHES developed an educational approach to stimulate demand for services provided through the program which included immunization; provision of ORS; nutritional surveillance of children and pregnant and lactating women; deworming; and vitamin supplementation. The nurse-auxiliaries were replaced by village-based peer educators called *kolaboratris* who were in turn supervised by CARE staff.

The educational program comprised a curriculum of over thirty lessons on such topics as the preparation and use of ORT, the importance of exclusive breast-feeding, infant feeding, and common childhood illnesses and accidents. Monthly or bimonthly RICHES days were held at fixed health posts for mothers where they were given a lesson followed by the delivery of one or more of the health services. Lessons were given by the *kolaboratris*. Health committees were organized at all RICHES centers with the hope that they would continue health education activities when the project came to an end.

Extensive field research was conducted by an anthropologist and other CARE staff members prior to the development of the curriculum in the rural areas where the RICHES program was to take place. The results of this research were used to develop a creative, message-based curriculum which incorporated proverbs, songs and riddles from Haitian culture. Program evaluators called RICHES “possibly the most culturally appropriate, research-based and field-tested model for health education of non-literate and low-literacy women in Haiti today”.

In selected interventions, such as ORT use and knowledge, RICHES mothers demonstrated significantly higher knowledge of ORT function and higher user rates than national rates. The RICHES curriculum was also used by other NGOs in Haiti with similar mother and child health programs.

Due to the failure of the health committees to continue functioning after the project ended, a second phase of RICHES involved communities at the beginning through meetings whereby an explanation of the project and baseline studies were shared. Survey results were again shared with the community to motivate attendance in the RICHES program. In response to requests by RICHES participants, a family planning component was added which dramatically increased family planning coverage in several project sites. Two representatives from each community were designated as “messengers” to mobilize children and women for RICHES health activities. These messengers received quarterly training in various health topics and in problem-solving such as how to increase immunization coverage in their locality.

Educational Approach

Research and Data Collection Methodologies

Field research was conducted by an anthropologist working for CARE/Haiti who had extensive knowledge of rural Haiti. She worked with other CARE staff and health volunteers to conduct qualitative studies in the geographic areas where RICHES activities took place. Some of the major issues and problem areas in infant feeding identified through this research included use of a prelacteal purgative called *lok* (a mixture of castor oil, grated nutmeg, unrefined sugar, garlic, orange juice and water) administered to infants before they are put on the breast, delayed initiation of breastfeeding of neonates, giving of sugar water or tea in the first week of life and discarding of colostrum.

The results of this research were used to develop appropriate messages for the RICHES health education curriculum. This research methodology illustrates the Rapid Appraisal Procedures (RAP) which is open to and inquisitive of people concerning their perceptions of health – their knowledge, attitudes and practices and is concerned with indigenous perceptions of health. RICHES staff gathered this information both to formulate messages and to determine appropriate media/means of communication. Communities had input into the content (terms, ideas) of health messages as well as the means.

Education Methodologies and Theoretical Base

The RICHES curriculum was designed for a non-literate Creole-speaking audience and included songs using familiar melodies, skits and riddles to enhance recall of the health messages. Careful field testing ensured that the wording in Creole was clear and unequivocal. A written guide was developed for use by the RICHES educators which included lessons on such topics as prenatal nutrition, importance of colostrum, feeding of children with diarrhea, and the value of breastfeeding. The lessons in the guide contained two to three basic messages on the topic presented succinctly. The messages used clever plays on words such as “dechouke bibwon” – which literally means uproot (or destroy) bottles. The term *dechouke* is universally known in Haiti and used to describe the rioting and destruction of property which followed Jean Claude Duvalier’s fall from power. Messages built on cultural beliefs and also highlighted economic advantages of the promoted practice. For example, to promote feeding of colostrum to newborns, largely unpracticed in rural Haiti where colostrum is discarded, the RICHES message turned a negative cultural practice, that of giving *lok* as a purge to newborns, into a positive message: colostrum is the BEST *lok*.

The RICHES curriculum was easy to use by low-literate health workers and its simple, culturally-appropriate content made it easy for mothers to learn and to recall. RICHES health educators were trained to respect participants’ knowledge and situation and the lessons typically began with a discussion of mothers’ current practices and behaviors on the particular topic. Diffusion of messages through teaching the women the songs or performing skits followed and women were questioned to ensure the message was understood. Lessons ended with a discussion of how the women would implement the particular behavior in her home.

Mothers who attended RICHES educational sessions were designated as *fam mesaje* or messengers to diffuse the health message to other members of their family and neighbors. Program evaluators found that other family members of participating mothers, such as young girls, could accurately recite the lesson content without hesitation and readily sang RICHES songs.

Most of the RICHES health messages were supported by appropriate services to ensure behavior change was possible, such as community-based supplies of family planning and ORS packets. However, the nutrition component was hampered by increasing scarcity of economic and food resources in rural Haiti and a poor policy environment where a strictly educational approach could only do so much. Concerning the RICHES nutrition component, one program evaluator wrote that “Moun-yo pap kapab mete mesaj non chodye” or people cannot put messages into a cooking pot.

Worldview and Participation

The research methodology used to develop the RICHES curriculum is an example of extractive, **RAP methodologies used in health communication**. Here information is largely elicited and analyzed apart from community members, even though it did “return” to them in the form of the RICHES health and nutrition messages.

The participatory nature of the RICHES program focuses on the nature of the RICHES lessons where women learned songs and discussed content and application of messages with the collaborators. Discussion allowed women to better understand the “why” of primary health care services such as immunization. Participation also occurred through the meetings and discussions held with community members to inform them of the RICHES program and understand their community’s current status in terms of health behaviors (percentage of fully immunized children in their community for example). This activity helped motivate and mobilize community members to improve health behaviors. In terms of participation, it represents an informing and consultative stage. Participation is a means of reinforcing the ultimate goal of message delivery and behavior change.

Case Study Resources

Interview with former RICHES Project Director – Susan Igras

Alvarey, M.D., G. Gerggren and M. Gay (1993) *Final Evaluation of CARE RICHES Project*. Port au Prince, Haiti: CARE International

Case Study 4: The Weaning Project

Educational Approaches Illustrated

The Weaning Project clearly illustrates a **behavior change communication approach**. The focus of this project was on changing behavior in response to audience needs. A mix of methodologies drawing from **anthropology, social marketing and social learning theory** were applied in the Weaning Project. These included an elaborate qualitative research protocol, audience segmentation and education of families in feeding practices. Program strategy formulation paid attention to both individual behavior change in child feeding and structural changes (such as legislation and service delivery improvements) which support behavior change.

Description of the Weaning Project

The Weaning Project was a six-country, five-year project supported by the Office of Nutrition of the Agency for International Development. The countries included Ecuador, Ghana, northern Cameroon, Swaziland, Indonesia and Zaire. Partnerships were formed at the country level with either UNICEF, CARE or USAID missions and relations maintained with Ministries of Health, Agriculture or Community Development.

The Weaning Project's strategies were defined for each country after a thorough assessment and included legislation on the Code for the Marketing of Breast Milk Substitutes; training of service delivery personnel such as nurses or community developers; message delivery through varied media such as counseling cards, radio spots, cassettes, posters and flip charts; and caretaker education on appropriate weaning foods and feeding practices.

A formal evaluation of the Weaning Project in two countries showed significant behavior change and a shift in nutritional status of children in one country and major changes in child feeding practices in the other.

Educational Approach

Research and Data Collection Methodologies

The Weaning Project used a **formative research process**. An elaborate qualitative research protocol was used at the outset of the project. It was highly qualitative and in-depth, focusing on a small sample. Data collection included information on parents' aspirations for their children, expectations for child development and maternal self-confidence. Part of the assessment methodology involved field trials of recommendations. **Focus groups** were held not only with mothers but with men and policymakers. Analysis of the data compared ideal practices with real practices; information on what families indicated they can or will change; and examining resistance and enabling factors. Formulation of possible behavior change goals flowed from this analysis. The analysis was conducted by the principal investigator and research team members including project counterparts, Ministry of Health officials or people hired from a local market research company. These team members then returned to the field for concept testing to determine the potential for changing practices. Concept-testing included household trials of practices such as adding green leafy vegetables to a porridge in Indonesia.

Extensive community and beneficiary contacts were made to gather data and information which was then analyzed by project planners. The project planners then presented this information to program managers and policy makers representing key programs related to child health and nutrition during workshops where overall strategies were mapped out. The Weaning Project's approach is consistent with the extractive nature of research and data collection methodologies used in behavior change communication programs. Information is "extracted" from informants in order to improve the quality of the final strategies. This type of qualitative research emphasizes communication channels, target groups for a given communication activity, constraints to behavior change and adequate pre-testing of messages. Research yields information that is used by outsiders to develop health message strategies. Research results return to informants through the form of packaged messages.

Education Methodologies and Theoretical Base

Segmentation, a social marketing principle, was used in the Weaning Project. In this project the primary audience identified was mothers and principal caretakers as they prepare the food and feed the

children. Secondary audiences were influencers such as fathers or grandmothers. Tertiary audiences were influencers one step removed from the family such as key community leaders or health care workers. The Weaning project also practiced segmentation within these primary, secondary and tertiary audiences, for example distinguishing the concerns of mothers of newborns from mothers of older children. The media strategy was then developed for each of these segmented audiences. For example, the primary audience received messages focusing on specific behavior changes while the secondary audience received more general messages on child feeding. Messages to the primary audience were sent through a variety of creative communication channels such as counseling cards used by village health workers, radio spots and cassettes and posters. Messages to the secondary audience were sent through use of logos and songs over the radio. Cassettes were played at gathering places of men in Swaziland.

Principles of **social learning theory** were also applied in the Weaning Project especially through the emphasis on **distinguishing environmental and attitudinal resistance to change**. For example one important environmental barrier in each country was misinformation about child feeding by health care professionals. Attitudinal barriers included such ideas as the inability of children to swallow or digest particular foods or preparations. Maternal self-confidence was identified as a barrier in that a woman's low social status means she feels powerless in the face of resistance of the child to different foods or feeding practices. Enabling factors or motivators were also identified such as the significant role of fathers, especially in the purchase of calorie-dense foods for young children and the role of food vendors who are credible sources of information on food-related topics in communities. The interplay of behavior, environment and the person's cognitive processes illustrate the social learning concept of reciprocal determinism.

Worldview and Participation

The Weaning Project's goals of improving nutritional practices and ultimately nutritional status are **congruent with health communication's educational approach**. While structural changes in legislation and within government service delivery mechanisms were instituted, these actions reinforced the priority strategy of helping families improve their coping strategies within the existing conditions. As the Weaning Project's proponents state :

Of great importance, and what emerged resoundingly from all assessments, was that the majority of families could and would do more to improve conditions for their children. Enabling people to optimize their resources and current feeding patterns should become the priority.

Participation of project beneficiaries as informants occurred in the gathering of correct and culturally appropriate information. However, as receivers of messages, their role is passive.

Case Study Resources

Griffiths, M. (1992) "Defining Concepts and Strategies for Improving Young Child Feeding Practices: The Experiences of the Weaning Project" in P. Koniz-Booher (ed) *The Proceedings of an International Conference on Communication Strategies to Support Infant and Young Child Nutrition*. pp52-65. Ithaca: Cornell University

Case Study 5: Child Survival and Development Program Iringa, Tanzania

Educational Approaches Illustrated

The Child Survival and Development (CSD) Program illustrates an **empowerment education approach which incorporates both community organization (called social mobilization)** and popular education. With the overall goal of reducing infant malnutrition and mortality, this program emphasized capacity strengthening of villagers, mothers and politicians to analyze and assess nutritional problems and causes and take action. Attention to underlying causes of nutritional problems was strengthened by a conceptual framework showing symptoms, immediate causes, underlying causes and basic causes of malnutrition and economic and sociopolitical conditions were addressed such as the low status of women and poverty. An important concept in this program was animation, a means of conscientization. Program animators worked alongside community members to promote dialogue, interaction, conflict resolution and problem solving within communities.

Description of the Child Survival and Development Program

The Child Survival and Development Program in Tanzania is implemented by UNICEF in collaboration with the Government of Tanzania. It grew from a pilot nutrition program in Iringa, Tanzania begun in the mid-1980s and now serves nearly half the regions in Tanzania, serving over 2,000,000 children under five.

The CSD program is a **community-based, integrated development effort** centered around nutrition where communities generate accurate information, identify problems and improve their situation. The CSD's two objectives are to reduce child malnutrition and empower communities to individually and collectively gain greater control over their lives. After a process whereby communities focus on the problem of malnutrition and agree to address it, a number of activities are undertaken to reduce and eliminate malnutrition. These activities include:

- Systems development and support (monitoring and evaluation, training, infrastructure support)
- Maternal and child health care (improving child survival technical services such as family planning, control of diarrheal diseases, immunization, malaria treatment, etc. as well as training of village health workers and traditional birth attendants).
- Water and environmental sanitation
- Household food security
- Child care and development
- Income generating activities

Social mobilization is a crosscutting strategy that substantively involves the community in the process of developing, planning, implementing and evaluating the program. The process involves a variety of actors of different levels in society working on sustained social action around a commonly agreed-upon purpose or objective⁸. Villagers actively recognize health and nutrition problems, identify causes and solutions and implement activities to improve the situation. The importance of systematic data collection begins what UNICEF calls the “Triple A cycle” of assessment, analysis and action which mirrors the **Freirian concept of praxis**. A conceptual framework developed by UNICEF to better understand the causes of malnutrition is used in communities to better identify, understand and overcome the problem of nutrition. Project animators work in villages to identify potential resources as well as needs and alongside community members, village health committees and village health workers to raise awareness, and promote dialogue and debate around program components.

⁸ While social mobilization involves actors on different levels, for the purpose of this case study specific attention is focused on the community/village level.

The CSD program has developed over an extended period of time and results recorded in 1993 showed dramatic reduction of severe malnutrition rates and anecdotal evidence of reduction in child mortality.

Educational Approach

Research and Data Collection Methodologies

One of the jobs of a CSD animator is to cooperate with villagers to collect and analyze basic socio-economic data to better understand their real situation. A family registration system and growth monitoring allowed data to be collected on numbers and causes of deaths; numbers of children classified as moderately or severely malnourished; and percentages of children immunized. This data is used by animators who assist villagers to first analyze the data and then with the help of the UNICEF conceptual framework to discuss immediate, structural and basic causes of death and malnutrition. This helps galvanize communities into action. Further data analysis is also used to help prioritize actions such as targeting severely malnourished children to begin with. Villager leaders and village health workers also use the data for performance reviews. During Village Health Days, the percentage of under-fives participating in weighing sessions and their outcomes are reviewed to determine progress.

This continual and shifting use of research and data collection illustrates participatory research methodologies. In the CSD program, **information is not extracted but generated and punctually analyzed in a participatory way by outsiders and community members.** The goal of this kind of data collection is to promote inspection and analysis of the data by those who generate it.

Education Methodologies and Theoretical Base

The CSD program draws extensively from **critical theory and Freirian concepts related to popular education.** Popular education's **problem-posing methodology** is widely used within the CSD program for health and nutrition-related issues. **Codes** are used to help villagers **visualize generative themes** after which open-ended discussions are held to promote critical reflection and find solutions. An example of this methodology involved a discussion on gender roles, child care and nutrition in the Mtwara region. A situation analysis conducted by animators and villagers uncovered one root cause of malnutrition as the hard life of village women and their many tasks, including child care, whereas men spent much time drinking and gambling. This **generative theme** was then acted out in role-plays which allowed villagers to focus on the problem without blaming specific community members. Rather than advocating a blueprint solution, the animators used dialogue to enable villagers to discuss the problems presented in the role play and to define specific activities for their own situation. In some sites, this resulted in community sanctions against irresponsible men such as fines and passage of by-laws which govern the hours that local bars can operate. A second example of problem-posing education and the development of codes involved the design of a case study in the Hai District that described conflicts between a village women's organization and government officials over land ownership.

Behavior change communication's emphasis on individual behavioral change and creation of a supportive environment was undertaken by the CSD through education by trained village health workers of caretakers in child feeding, diarrheal disease management, and immunization and strengthening of governmental services such as mother/child health services at regional hospitals. These actions dealt with the immediate causes of poor health and malnutrition such as disease and inadequate dietary intake. However, the CSD program also emphasized **capacity-building** through training of village leaders and workers, ward, district and regional officials and party leaders and national decision-makers at Ministry levels as a key strategy in reducing malnutrition. Capacity building is felt to address the underlying causes (household food insecurity, inadequate maternal and child care and insufficient health services and an unhealthy environment) of malnutrition and death. This strategy reflects popular education's attention

to root or structural causes of problems and community organization's emphasis on capacity building as a key educational methodology.

Worldview and Participation

The CSD program falls neatly within the category of **empowerment health education** due to its emphasis on the **process objective of social mobilization**. Empowerment of communities is considered a goal to be pursued simultaneously with the nutrition and health objective and is considered equally important: not a means to an end but an end in itself. Through the animation process, communities and individuals transformed the way they viewed their world and their place in it and became more willing to challenge injustice and act on their own initiative. This clearly reflects the empowerment health education worldview that poor health and nutrition is due to lack of critical reflection skills of individuals and communities.

CSD program staff recognizes that **conflict exists at all levels which affects the nutrition and health program**. Gender oppression, class issues and relations between villagers and government structures were revealed through various processes of social mobilization and debate and better communication encouraged. This illustrates the worldview of empowerment health education approaches whereby one cause of poor health and nutrition is related to unequal distribution of power in society.

Case Study Resources

This case study drew from the following two documents. In addition, Janis Lindsteadt, one of the UNICEF document authors and researchers reviewed the case study.

Olson, C. and M.T. Cerquiera. (1995) "Nutrition Education in Developing Countries: An Examination of Recent Successful Projects" in P. Pinstруп-Andersen, D. Pelletier and H. Alderman (eds) *Child Growth and Nutrition in Developing Countries: Priorities for Action*. 53-77. Ithaca: Cornell University Press.

UNICEF. (1993) "*We Will Never Go Back*": *Social Mobilization in the Child Survival and Development Programme in the United Republic of Tanzania*. New York: UNICEF.

Case Study 6: NGO Coalition for the Prevention of HIV/AIDS

Educational Approaches Illustrated

The NGO Coalition project illustrates a **community organization approach** to health education, in this case, HIV/AIDS prevention undertaken in the Central Plateau region of Haiti by Save the Children Federation. Here, the **"community" consisted of 10 NGOs** located in the Central Plateau who provide health and development services in a prescribed geographic location and whose previous institutional collaboration was minimal due to both isolation and lack of government coordinating bodies.

Description of the NGO Coalition Project

This project was spearheaded by Save the Children who implemented its own service delivery/community development project in rural communities in the district of Maissade. Nine other major NGOs work in the Central Plateau region in Haiti where Maissade is located, including both national and international organizations. Each NGO reached populations from 30,000 to over 100,000, providing most of the Central Plateau's services in immunization, nutrition and other child survival interventions. Some of the NGOs operated clinics and hospitals but also provided development services such as credit, literacy training and organization of women's clubs.

The NGO Coalition for the Prevention of AIDS and STDs in the Central Plateau was funded by the AIDSCAP project and coordinated activities of local NGOs and PVOs to orchestrate a comprehensive regional AIDS prevention program. Under the Coalition project, SCF provided technical assistance, training and materials to NGO and Ministry of Health staff in the region. Project interventions included revising and developing educational materials for the NGOs, improvement of condom distribution systems and improvement of STD services.

The Coalition was organized according to a **community development process** that SCF **normally applied in community-based rural development projects**. The process for the NGOs included: an inventory of NGO services needs and resources; joint collaborative planning to develop project activities; clear designation of the roles and responsibilities of SCF as coalition coordinator and NGOs as coalition members; and establishment of a monitoring and evaluation process.

Based on the **needs and resources inventory** of NGO services, SCF worked with NGO leaders and field managers to design activities to appeal to both the individual interests of the NGOs and to their desire to work collectively.

Educational Methodologies and Theoretical Base

An example of community organization methodologies used in the Coalition project involved conducting a needs and resource assessment at the beginning of the project. While needs and resource assessments are commonly undertaken in many health education approaches, the results of this assessment were presented back to NGO health program managers in an open-ended **discussion and negotiation session**. The assessment was used as a “consciousness-raising” tool to sensitize health program managers to discover themselves what the needs and issues in HIV/AIDS prevention were collectively. In general, NGO health managers were somewhat horrified to learn that different and sometimes incorrect algorithms were being used for STD diagnosis and treatment within their clinics, that their health education efforts ranged from “exhortations” to a sophisticated video developed by rural women themselves, and that condoms were inconsistently available and poorly stored in some locations. Using small group discussion, the NGO health managers reviewed proposed program interventions and refined and modified them to best meet their needs for improved HIV and STD programming. The resulting intervention for STD prevention and control involved organizing a workshop for NGO staff where top specialists were invited to present appropriate algorithms and the latest information on drug resistance and work with participants to develop the most appropriate algorithms and recommendations based on actual conditions within the Central Plateau.

SCF organized a **training of trainers in popular education** as the preferred educational methodology to train the NGO health managers. Training these managers in **problem-posing** educational methodologies was thus promoted rather than development of messages for dissemination through communication channels.

Dialogue between NGOs, the government and donor representatives was encouraged through holding of quarterly coordinating meetings. During these meetings, members’ activities were monitored and adjusted, reports on follow-up measures taken to address resolutions raised at previous meetings were given. The meetings also provided a forum for the members to share information. This was critical in Haiti, where at that time no concerted government response to AIDS was forthcoming. Lastly, the meetings provided a means for NGO members to vent any frustrations, questions or other feedback for the SCF Coalition coordinator to consider. In one instance, the NGOs were able to collectively criticize the government representative

The NGO Coalition thus illustrates the **community organization process by which groups are helped**

to identify common problems or goals, mobilize resources and develop and implement strategies for reaching these goals. Through this process NGOs increased their capacities for AIDS and STD programming. The NGO coalition used the needs and resource assessment to help NGO health managers to identify their own common problem in AIDS and STD interventions which helped or hindered them to reach the common goal of AIDS and STD prevention in their project locations. Existing resources such as NGO laboratory centers, educational resources etc. were used more strategically and efficiently and resources, such as popular education trainers or STD experts, were mobilized from the outside. The NGO program managers to a great extent, defined their own strategies, applicable to their particular environment and organizational skills, to improve AIDS and STD programming.

Worldview and Participation

The NGO Coalition's community organization strategy engaged NGO health managers in raising their **collective awareness** of problems and conditions around a pre-defined health topic of AIDS and STD prevention. **Collective problem solving** was promoted both through the preliminary needs and resource assessment and through regular quarterly meetings. However, the project **stopped short of more radical transformation of underlying structural or root causes**, although some individual NGOs did address these in their own programs (through a women's literacy and empowerment program for example). Root causes of AIDS in Haiti include broader issues of peasants' access to land, political problems and male/female power relationships. The NGO Coalition had a more "reform" agenda in that it focused on how to make existing resources more accessible and efficient within the given social and political situation.

Case Study Resources

Stetson, V. and M. Narcisse-Prudent. 1994. "Improving NGO Collaboration in AIDS Prevention in Rural Haiti" *AIDSCaptions* 1(2):23-25.

CONCLUSION

The authors of this paper are not advocating one health education approach over another. Rather, the purpose of this paper is to assist NGO health educators to reflect on and critically analyze their health education efforts to date and more purposefully choose health education approach(es) which best fit their needs, goals and organizational values. Wallerstein and Bernstein (1994) write that health educators need a broad repertoire of approaches to match various needs of communities, organizations and individuals in order to meet changing conditions and opportunities.

NGOs in developing country contexts must respond to donor requirements, national government policies and administrative requirements of local authorities in addition to maintaining their organizational goals and values which may include working with the poor and disenfranchised, promotion of participation and achievement of better health status. In the pursuit of this complex mission, it is hoped that a better understanding of health education approaches and their related research and data collection methodologies will be of help.

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