The Elements of Health Education in Good Public Health Programs

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AS THEMES, the elements of a good public health education program, or what public health education can contribute to a good public health program, are fields of discussion which have been virtually tilled to exhaustion. In contrast, our colleagues in Pennsylvania have taken a completely fresh approach. Instead of looking at public health through the eyes of health education, they have proposed to turn around and examine health education from the broad perspective of public health.

Yet another aspect of this approach is the assumption that a good public health program does have at least some elements of education built into it. This assumption is one about which I hope there will be little controversy.

The objective of any good public health program is a favorable effect on the health status of the citizens of a community, whether that community is a municipality, a State, a nation or, for that matter, the world. Such an objective, by its nature, implies change, except in rare circumstances when perfection is to be maintained. Almost without exception, accomplishing this objective requires some intended changes of attitude and behavior among those affected. This premise applies as much to yaws control deep in Africa as to our own efforts to vaccinate against poliomyelitis.

Since an intentional change of attitudes, beliefs, and behavior is, I believe admittedly, inherent in a good public health program, we may then ask, what process is chiefly instrumental in bringing this about? Through the techniques of education, which include study, communication, and demonstration, we seek to impart health information and at the same time motivate the individual to use that information for the protection of his health.

To see this process for what it is and to improve it is the hope of every director of public health.

Most of us in public health have some familiarity with educational principles; either through formal training or from day-to-day experience. I suspect that there is hardly a public health program launched today which does not at least give lip service to "public health education."

But how many programs allow for the thought, the time, and the facilities for their educational phase? How many introduce the educational function at the beginning and keep it bound to the core of the program until the end? Is there a seat at the table for this function at the first planning session? Is it occupied by someone especially qualified by experience and training, with knowledge of the program both at the giving and receiving end, with sense and judgment in the realm of science, the social sciences, and public health practice, with skills in communication and organization? Although education is a function shared by all members of a health agency, wise health directors, when they can, employ the services of a specialist in this function, even as they employ specialists in pathology, nursing, engineering, and statistics.

Especially with respect to short-term pro-

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grams, successful programs rely on three elements of education. The first is communication.

Many public health programs have faltered through neglect of communications. Sometimes the staff themselves are ill-informed about the program, its objectives, and how it is to be carried out. It is not unusual for staff members to say, "I don't know anything about it; I just work here; nobody ever tells me anything." The remark, often passed half in jest, half in bitterness, reflects a breakdown of communications that can easily be met by meetings and written outlines. In some agencies, it is met in the process of preparing program descriptions and progress reports by staff members.

From this beginning, the chain of communication extends to all others directly concerned. Depending on the nature of the program, they include key people in institutions and organizations, such as voluntary and official health agencies, professional societies such as those of medicine, nursing, and engineering, the schools, and civic groups. It is a truism that public information is meant not for a single audience but for a mosaic of audiences. There is really not a "general" public, but many smaller "individual" publics.

Communications with these audiences, however complete and thorough, are successful to the degree that they are arranged to reach the respective audiences in proper sequence and at an effective time. In a poliomyelitis vaccination program, for example, communications are timed to reach physicians before they do lay groups, and they may go to medical leaders before they go to the medical society as a whole. By such means, understanding and cooperation may develop systematically.

The communications process has its genesis in the joint planning that accompanies the development of any public health program. Properly carried out, such joint planning brings to the conference table representation from all the groups who will have an active role in the program, as well as those who will be reached by the program. These conferences are in themselves a phase of communication, which is by definition a two-way flow of information.

The second element of education is the substance of the "information" itself, especially that which goes out rather than what comes in. If it be desired that the maximum number of individuals in the community learn about the program, the need for it, and the reasons for the course of action recommended, the most practical course is to supply the facts through newspapers, radio, television, and other mass media. The technique applies when it is desirable to disseminate information about the program accurately, quickly, and to the largest audience possible.

The third element, supplementing communication to the general public, seeks participation of a multitude of social units. This element is usually called community organization. These social units each have their own core: a neighborhood, a church, a lodge, a profession, trade, business, or civic interest, a school, ethnic background, a sporting interest, a hobby, or a cause. The specialist studies the community's structure to search out these discrete groups and their organizational structure, so as to develop effective lines of communication with their members. In so doing, the information process extends from the mass media to a specialized and personal relation with each group.

It is an axiom that the mere possession or transmission of information is not the ultimate objective. Information, unless acted upon, is of only academic interest. From the efforts to put information to use comes the term "community involvement," expressive of the aim actually to involve social units and their members in the program.

Why is involvement an essential element of the process of education? First, it is generally accepted that involvement in the learning process strengthens that process. Second, involvement provides a motivating force. For example, when an organization devotes a meeting to a discussion of a health program, considers all aspects of it, pro and con, and takes a position on it, each member of the group becomes involved by being identified with the experience, reviewing the information, and assuming some emotional relation to the position voted. He is the more likely to develop an attitude or a course of behavior suggested by the unit than by independent experience.

Involvement may also take the form of volunteer service, in which members of the group assist with the program. Again, such involve-

ment provides a strong motivating force in changing attitudes and influencing behavior. Where one's work goes, so does one's interest. Given a fortunate experience, the volunteer learns the meaning and value of a program and becomes a staunch advocate and supporter. If his experience is unfortunate, of course, he may turn the more violently against it.

Finally, may we mention, not specifically as an element of the health education process but of prime importance nonetheless, one other factor. That is, the factor of "timing." We have already referred indirectly to timing in the sequential development of the communications process; now may we speak of it with respect to the community. It has been our observation that many public health programs have failed because of poor timing. Not only in the sense that the community was not yet ready for the program, but more particularly in the sense that timing is in itself important in the educational process.

For example, health agencies sometimes exhibit an unhappy tendency to move too fast in carrying out programs which require active participation on the part of individuals in the community. It appears quite clear that there is as definite an "incubation period" with respect to the lag between the time the community is informed and the community acts as there is between the time of exposure to a disease and the development of the first symptoms.

Even as this incubation period varies with individual diseases, so does it vary with different public health programs. It is to be noted that, for some diseases, this period is quite short. Similarly, in a real health emergency, we are all sometimes surprised how quickly a community becomes informed and how rapidly it responds. In general, however, there is a lag of weeks or even months between the informational and action phases of a public health program. Without proper timing of information in relation to action, the best laid public health programs go awry.

How fast one may move depends on the nature of the program, the size of the community, the structure of the community, and a number of other factors. The final decision as to timing must in the last analysis depend on judgment based in turn upon experience, a thorough knowledge of the factors involved, and a sensitive feeling for the responses of the public in each specific situation.

Summary

In summary, these assumptions are proposed for a working hypothesis:

1. That education of the staff, community leaders, and the public is essential to effective public health programs.
2. That public health programs are most likely to succeed to the extent that education is brought into the planning early and to the extent the specialists in education participate in the program planning.
3. That among the elements of education in a good public health program are (*a*) free and thorough communications, first within the agency itself and then with the individuals and groups especially affected or to be reached by the program; (*b*) detailed attention to the information process to the end that, when desirable, the community at large is informed through suitable mass media; (*c*) involvement of individuals in the community through the medium of the many social units which make up the general public.
4. That appreciation of the importance of timing will allow for a proper incubation period from the moment of the first information about the program until the hour for action.

Referee's Comments

In the past, there has been some controversy on the point that a health education program seeks "to motivate the individual . . . for the protection of his health." This controversy may be based on imaginary grounds.

It is possible to imagine an all-powerful government using base techniques to influence public behavior in a direction which its bureaucrats fondly believe is all for the best. It is not difficult to cite examples of governmental propaganda which, deliberately or not, has led a public to its own destruction.

On the other hand, it is almost impossible to conceive of a program of information which does not in one way or another imply an effort at motivation. If there were no effort at motivation, there would be no information.

The controversy therefore relates not to the existence of efforts to motivate society but to the nature of such efforts. However noble and altruistic the intent may be, it appears arrogant to assume a personal responsibility for seeing that others behave properly. Such arrogance, even as exercised by parents toward their children, arouses resentment and distrust. The question is, how can a health agency exercise responsibility without such arrogance?

An unemotional statement of the facts is as a rule an unimpeachable course. It is the course most public agencies seek to pursue, whether accounting to the public for their own expenditures, or advising the public of important news.

It may be argued that the facts on fluoridation, by themselves, have not always succeeded in overcoming emotional opposition. In such situations have public agencies fulfilled their responsibility? It may also be argued that the facts have seldom been presented so as to overcome legitimate doubts among the majority: the issue was permitted to be political rather than scientific.

An even more perplexing shortcoming in reliance upon simple fact concerns programs of radiation safety. In the absence of completely valid information which, for the moment, may decide the public course on a scientific basis, the issue of radioactive contamination has become almost wholly political. In this situation, how can unemotional information fulfill the health profession's responsibility? Is it sufficient to supplement unemotional fact with cold logic?

There is no intention here to claim that public behavior is on the whole determined either by facts or logic. Most behavior appears to be imitative and repetitive, or intuitive. Or it is influenced by a system of rewards and punishments, real or illusory. With such a pattern of public behavior, does a health agency abdicate responsibility when it confines education to fact and logic?

The escape from this corner appears to be an assumption that community leaders are influenced by fact and logic in a climate of knowledge and understanding, where their behavior may be understood to be rational. It may be further assumed that the response of the public, the mosaic of small publics, is to follow the leaders, even as children are more impressed by the example of their parents than by what their parents may tell them to do. The mass media, as noted above, are essential to creating a climate of knowledge and understanding: personal involvement will complete the work of fact and logic to suggest a course of action for the community leader.

The course may not be the course which the health profession looked for, but it will be one democratically determined by enlightened citizens.

Nobody deprecates legitimate efforts to bring facts and logic to public attention: the use of Monday datelines on press releases, colored ink, and eye-appealing layout and design of educational materials are all as legitimate in the tradition of communication as the Roman alphabet. The technique of presentation goes false, it seems, when logic is distorted, when irrelevant motives are abused, or when the facts themselves are twisted.

In the contemporary code of ethics, there seem to be no barriers to the half-truth, to the appeal to fear, libido, or status imagery; to the deadening of common sense by an inane repetition of a name or a slogan. But the resort to these devices in itself frustrates the objective of health. The healthy body implies a healthy mind. And a healthy mind is one that works, not one that is clouded with lies, base motives, or associations empty of meaning or value. For this reason, the techniques of motivation in a health program should tend to police themselves. And the controversy over the health agency's role in influencing behavior proves indeed to be imaginary.