

**ROLE OF HEALTH EDUCATION IN PROMOTING  
HEALTH IN LIBYA: EVALUATION OF THE  
EXISTING SITUATION AND ASSESSMENT OF  
FUTURE NEEDS**

A thesis submitted for the degree of Doctor of Philosophy

**by**

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**DECEMBER 2000**



## ACKNOWLEDGEMENTS

My sincere thanks go to all who made this study possible, to Professor Theodore H. MacDonald, my supervisor, for his time, support, guidance and advice. Special thanks to my local supervisor, Professor Mohamed S. Elmahaishi for his help and support.

My thanks also go to the collaboration of my colleagues, the members of the National Committee for Health and Social Education, in particular to Mr. Habib Tamer for his technical advice and to Dr. Khaled Gadgood for his administrative support.

I also want to thank Dr. Abdulhamid Ali, Mr. Belaid Ghaith, Mr. Jamal Bordon, Mr. Mohamed Elhabroush, Mr. Ali Aburawi, Dr. Khaled Sbeta, Dr. Awad Elgwairi, Miss. Amna Zlitni, my brother Adel, my sisters Majda, Nadia, Nuzha and Zuhur, and my relatives Jamal, Sabah and Nawal Elfituri for their kind assistance in handing out the questionnaires, Dr. Mohamed Smaio for giving valuable suggestions for the analysis of data, and Mr. Khaled Aburowneia, Mr. Elhashmi Elainie, Miss. Basma Addous and Miss. Amna Zleitni for their secretarial assistance and entering data to the computer.

As well, I should thank my colleagues, the National Managers of Primary Health Care and Health Promotion Programmes, the Directors of Primary Health Care Departments in the local districts, and all other health promotion officials who participated in this study. Special thanks go to the ex-under secretaries for their participation.

My thanks also go to Dr. Abdurazak Traish, the National Representative of WHO in Libya, and Dr. Chafik Sallah, the Ex-Director of UNICEF Office in Tripoli, for the bibliography they gave to me.

My sincere gratitude to the World Health Organisation, Eastern Mediterranean Regional Office, in Alexandria for awarding me the scholarship, and particularly Dr. Mohammed Elkhateeb, the Ex-Regional Advisor of Health Education, for his encouragement and support.



## **DEDICATION**

I dedicate this little work to my small family - parents, brothers and sisters;  
and to my large family - Libya.



## PUBLICATIONS AND PRESENTATIONS

A number of papers out of this research have been published and presented as following:

- Effectiveness of Health Education Media: Comparing Public Evaluation with that of Health Education/Promotion Officials in an Arab Country.  
-*Sixteenth World Conference on Health Promotion and Health Education, Puerto Rico, USA, 1998.*
- Evaluating the National Programme for Health Education.  
-*Fourth Jamahiria Medical Sciences Congress, Benghazi, Libya, 1998.*
- Role of Health Education Programme within the Libyan Community.  
-*Eastern Mediterranean Health Journal, 1999, WHO, March, vol. 5(2), p. 268-276.*
- Evaluation of the Libyan Programme for Health Education.  
-*Fifth Global Conference on Health Promotion, Mexico City, Mexico, 2000.*

Two other papers have been recently submitted for presentation at the *Seventeenth World Conference on Health Promotion and Health Education, Paris, France, July, 2001*. They are:

- Health Education in Libya: Assessment of Future Needs.
- Health Professionals' Perceptions about Health Education Practice.



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## ABBREVIATIONS AND EXPRESSIONS

AIDS	= Acquired Immune Deficiency Syndrome.
DPT	= Diphtheria, Pertussis (Whooping Cough) and Tetanus.
GSH	= The General Secretariat of Health, Libya
GSHSW	= The General Secretariat of Health and Social Welfare, Libya
HEA	= Health Education Authority of England.
HIV	= Human Immuno-deficiency Virus
LSMCH	= The Libyan Survey on Maternal and Child Health.
NADI	= National Authority for Documentation and Information, Libya
NCHSE	= National Committee for Health and Social Education, Libya
NGO	= Non Governmental Organisation
ORT use	= Percentage of all cases of diarrhoea in children under five years of age treated with Oral Rehydration Salts or recommended home fluids
PAHO	= Pan American Health Organisation
TB	= Tuberculosis.
UN	= United Nations
UNICEF	= United Nations Children's Fund.
WHO	= World Health Organisation.
Arab Maghrabian Countries	= Libya, Tunisia, Algeria, Morocco, and Mauritania.
Child (Under Five) Mortality Rate	= Probability of dying between birth and exactly five years of age expressed per 1,000 live births.
Infant (Under One) Mortality Rate	= Probability of dying between birth and exactly one year of age expressed per 1,000 live births.
Maternal Mortality Rate	= Annual number of deaths of women from pregnancy related causes per 100,000 live births.
Low Birth Weight	= Less than 2,500 grams.
Life Expectancy at Birth	= The number of years new-born children would live if subject to the mortality risks prevailing for the cross section of population at the time of their birth.



## ABSTRACT

A variety of programmes of health education are designed, addressing promotion of health of the Libyan community. These programmes employ various communication methods and use different education media.

This research is the first to evaluate the national programmes of health education in Libya and to determine future needs. It compares health officials' assessments with those of the general public; providers and users. It also examines the health professionals' perceptions on their role in health education.

Five questionnaires are used in this research. The first two questionnaires are designed for the evaluation purpose. The third and fourth questionnaires are to determine future needs. The fifth questionnaire is about health professionals' role in health education.

Both of the groups, the officials and the general public, assessed TV as being the most effective health education medium. The general public favoured the 'spots' over regular programmes. Their assessment of the radio effectiveness was much lower. Officials, on the other hand, favoured regular programmes over 'spots', and placed radio's role only slightly lower than the impact of TV. Both of the groups recommended wide use of TV for future health education. Children and youth are considered the main groups to be targeted with respect to most of health issues. School is the most preferred setting to target the children. Youth and sport clubs are recommended in communicating with the youth. Assessment of future priority health issues attracted different responses from the two groups.

Health professionals perceive that they are responsible for mediating health education and consider this role as important. However, effectiveness of the existing role of health professionals in health education in Libya is evaluated differently. Main barriers to an effective role are identified and required solutions are suggested.



The findings of this research suggest the need for systematic consultation across professional and lay groups as a requisite preliminary for statutory health education/promotion initiatives. These findings also address the need for further work and research in certain areas.



# **CHAPTER ONE**

## **INTRODUCTION**



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## CHAPTER ONE

### INTRODUCTION

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The term '*health promotion*' refers to any activity designed to foster health. It covers all aspects of those activities that seek to improve the health status of individuals and communities (Tannahill, 1985).

People have the need for and the right to information on how to maintain, protect and promote health. Giving people the information and ability to make a choice must therefore be an essential and important component of the health for all strategy (WHO, 1994).

Health education is seen as a very important element in health promotion, it is one route to the improvement of people's health, and encompasses all those activities which aim to provide health via learning of one kind or another.

The standard of education of the Libyan people about health protection and its promotion has been raised within the past 20-25 years (GSHSW, 1994). The Libyan Survey on Maternal and Child Health (1996) showed a spectacular decline in infant and maternal mortality rates, an extraordinary success in the national immunisation programme and a dramatic drop in the incidence of vaccine-preventable diseases. The national report "Libya: Human Development Report" (NADI, 2000a) highlighted a host of other measurable health improvements.

These changes and improvements can be attributed to the National Strategy of Health Promotion in the country, intended to provide health for all and by all, giving priority to primary health care in all aspects. Health education activity integrates with and represents an important element of each of the health care aspects (Tamer et al., 1990).

Health Education programmes in Libya are planned to present opportunities for people to think about health and to undertake voluntary changes



in their health-related behaviour. They include providing information, exploring values and attitudes, making health decisions and acquiring skills to enable behaviour change to take place, and they involve promoting self-esteem and self-empowerment, so that people are enabled to take action about their health (Abdelhadi et al., 1997).

The National Committee for Health and Social Education organises programmes, projects, training and research and also supports health and related boards and local authorities with their own health education activities.

It provides information and advice about health directly to members of the public, and supports other organisations and people who provide health education to members of the public. This is accomplished by using the most appropriate, acceptable and effective means of achieving the stated aims and objectives.

A variety of methods, both formal and informal, are used. Some are *personal*, i.e. involving a health worker in direct contact with an individual or a group. Others are *corporate*, in which the communication does not involve such contact e.g. the use of posters, leaflets, and the mass media (newspapers, radio and TV). In particular, it concentrates on the mass media as this is an effective way of drawing the attention of the public to health issues, which then become a matter of public interest and debate (Elfituri, 1996).

The level of comprehension of health messages varies with the mores of different groups in the community and the channels of information open to them.

In order to insure that health education programmes are functioning properly, a process of evaluation has to be built in (Hawe et al., 1991; Doyle & Thomas, 1996). Moreover, needs assessment is essential for future planning (Framework for Countrywide Plans of Action for Health Promotion, 2000) and community participation in the processes of evaluation and future planning is crucial (Ottawa Charter for Health Promotion, 1986).



However, very little research has been done on the organisation and management of health education services and their elaboration in the developing countries (*including Libya*), (Dehne & Hubley, 1993). No single study to evaluate the National Health Education Programmes or to assess future needs in Libya has been carried out.

This research is the first in Libya to evaluate and enhance the existing health education activities and to suggest modifications and amelioration.

It is to analyse and evaluate the overall effectiveness and efficiency of the existing National Health Education Programmes on the health promotion of the Libyan community, in order to determine the most successful programmes and most efficient media. It assesses population future needs, in terms of priority health issues, suggested targeted groups and recommended educational media. The research examines health professionals' perceptions about their role in health education, determines barriers to an effective role, and suggests actions for improving the service.

This research consists of three parts. Part one is to evaluate the existing situation, part two is to assess future needs, and part three is to examine health professionals' perceptions about their role in health education.

Five questionnaires are used in this research. Two of them are used in the first part to target two groups; the health officials and the general public (providers and users). The officials' questionnaire is intended to assess health education programmes and media, their effectiveness and efficiency, and the role of health education interventions within the main health promotion programmes, and implications and recommendations for future health education.

The general public form addressed enquiries about health knowledge and healthy behaviour and asked whether or not health education programmes have an effect on the promotion of health, what is the effectiveness of different



communication media, and who/what influencing factors lead one to adopt healthy behaviours.

Two other questionnaires are posed in the second part of this research to target the health officials and the general public again. The two groups are questioned about health issues and groups of people, which, and to whom, future health education programmes should address and be directed. They are requested to indicate which of the media have to be employed for each issue and group of people. As well, they are requested to report their recommendations and suggestions for future planning.

The fifth questionnaire is designed in the third part of this research to understand the health professionals' view on their role in health education; their responsibility for health education to the general public and the importance of this role. They are requested to assess the existing role of health professionals in health education in Libya. They are asked as well to identify the main barriers to health professionals' role in health education and to suggest solutions for improving the service.

The project includes collection and analysis of biodata about the national health targets covered by the health education programmes, (such as infant, child and maternal mortality rates, vaccination rate, life expectancy at birth, etc.). It discusses the obtained findings in the light of similar studies around the globe.

The author will also draw on published literature as well as on his personal experience, as a General Director of National Health Education Programmes in Libya since 1992, and as a Temporary Adviser for the World Health Organisation (WHO), to analyse and discuss the wider implications of the National Health Education Programmes and to identify areas for further work and research.



# **CHAPTER TWO**

## **LITERATURE REVIEW**



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## CHAPTER TWO

### LITERATURE REVIEW

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#### 2.1 The Concept of "Health"

"Health is created and lived by people within the settings of their everyday lives; where they learn, work, play and love. Health is created by caring for one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members" (Ottawa Charter for Health Promotion, 1986).

Health has been a prime concern of humanity since the dawn of history. It has long been established that the concept of health is ambiguous. Hunt and his colleagues (1981) note that, with health, it is easier to specify departures from the norm than it is to specify the norm itself. It is also easier to identify certain behaviours which we consider to be healthy than to define health itself.

"Being healthy" means different things to different people (Seedhouse, 1986). It varies between lay and professional persons and it is essentially subjective (Reynolds, 1996), therefore making it difficult to define. Much has been researched and written about peoples' varying conceptions of health, analysis of which falls outside the remit of this thesis.

Literary definitions of health have varied from the simple 'absence of disease', commonly used by some lay individuals (Blaxter, 1990), to the most widely used multidimensional interpretation given by the WHO as "*A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity*" (WHO, 1946).

Health can be seen by the professionals in the field as "freedom from medically-defined diseases and disability" (Richman, 1987; Webb, 1994), or has



been viewed more objectively as “wholeness; a metaphysical and ecological balance of self with the social and material environment” (Garman, 1996).

However, the WHO definition was criticised, as it is unrealistic and idealistic, or implies a static position, whereas life and living are anything but static. Seedhouse (1986) defines ‘health’ as “the state or the set of conditions which fulfil his or her realistic chosen and biological potentials. King (1990) adapts the WHO definition of health to: “a *sustainable* state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity”.

The National Policy of Health in Libya defines health as “*not merely the absence of disease or infirmity, but a complete state of physical, mental and social well-being enabling him/her to work, and is expressed in production and development*” (The General Secretariat of Health, 1989).

Attempts to advance the understanding of health and its determinants have led to the introduction of the *Salutogenic* approach (Antonovski, 1984). The term ‘Salutogenesis’ refers to the production of health as an alternative paradigm, instead of a focus on pathogenesis.

The positive concept of health has been described as a potentiality - the ability of an individual or a social group to modify himself or itself continually, in the face of changing conditions of life (Dubos, 1960).

Health can be, and arguably should be, seen as a resource for every day life, not the sole objective of living. It is a positive concept emphasising social resources, as well as physical capacities (WHO, 1984). Health is central to the well-being of individuals and the sustainable development of communities (WHO, 1992).

Health co-operatives in Japan have their own understanding of human health. From the view point of health co-operatives, a meaning of human health may be those physical, mental and social conditions that make it possible for people



to live day after day more actively and pleasantly, to act and reform the social circumstances in order to realise such a daily life. In other words, they think that human health means to pursue the movements that make it possible for everybody to live pleasantly, brightly and positively based on the co-operation (Health Co-operatives Association of JCCU, 1998).

## **2.2 Prerequisites for Health**

In the last 150 years, in the developed world, there has been a dramatic change in the epidemiological patterns of ill-health. Much has been published already on the fact that in the more advanced industrialised nations of Europe -as well as world-wide- there has been a reduction in the massive toll of infectious diseases such as cholera, poliomyelitis, tuberculosis, etc. These were the epidemics which typically affected populations in earlier stages of urbanisation (McKeown, 1971). Using data from England and Wales, McKeown (1976) confirms that the halving of mortality rates (from 23/1000 in 1851 to 11/1000 in 1980) and the doubling of life expectancy (women: from 40 years in 1840 to 76 years in 1980; men: from 43 years to 70 years) are explained by the reduction of infectious causes of death associated with improvements in the environment (e.g. the introduction of sanitation measures), living conditions (e.g. better housing and nutrition), and other factors related to social and economic development (e.g. increased family income). Similar conclusions have been reached from studies carried out in several other countries. Medical breakthroughs, such as the availability of vaccination and antibiotics, came after the Second World War, by which time, the major drop in mortality rates had already occurred (McKeown & Record, 1962).

In developed countries, the receding pandemics of infection during the 18<sup>th</sup> and 19<sup>th</sup> centuries were more attributable to social, economic and environmental changes than to medical breakthroughs (McKeown, 1976). The latter were few and came too gradually and too late to be responsible for the changes in health and disease patterns. The policy implications of this knowledge are still largely overlooked. There is no doubt that this reduction in mortality is strongly linked to



improvements in living and working conditions brought about by social and economic development (Ziglio et al., 1998).

There has been much debate since the early 1970s about the relative importance of these many and varied postulated determinants of health. Nevertheless, the main determinants of health seem to lie outside the health sector (Faculty of Community Medicine, 1986; Baum & Sanders, 1995). For instance, one of the central concerns has been an increasing awareness that medicine -as professional practice- has had surprisingly, and disappointingly, little effect on the nation's health. Cochrane (1972) commented that the existing national health service has evolved as a treatment and care service for people who are ill, not as the major means of improving public health.

Hospitals can only cure, probably, between 10% and 20% of diseases (O'Neill, 1984). Instead of promoting health and preventing diseases, we have invested the bulk of our health budgets in 'disease places', which have only cured our acute illness. Of course, we cannot do without the medical care facilities that actually save life, but let us be clear that they do not necessarily add to our 'health'. They merely delay our death. Gro Harlem, Director-General, WHO, (1999) said in this context "Health is not just about hospitals, X-rays and tablets. Health is about life and living and individual and social responsibility".

Labonte (1997) argues that health professionals must form genuine alliance with the communities they serve, in order to engage in effective health promotion and public health work.

Throughout the history of medicine, primary medical care has been by far the most important approach in providing health services. The horse and buggy physician and his predecessors through the ages were clearly practitioners of primary medical care.

With all the modern advances, however the hospital became the natural workshop of the doctor. The value of primary health care, which could have kept



many people out of hospital was more and more ignored and the result was the neglect of their health. There is no doubt that the developed world, as it sees newly designed schemes being brought forward in the developing countries, has become more aware of the need to move back to community care. There is much to be learned from the long traditions of community care in those countries as well as from the new schemes (O'Neill, 1984).

Ziglio and his colleagues (2000) says in this context: that to argue that falls in death rates and the decline of pandemics in the last two centuries have been primarily related to changes in the environment, in the nutritional status of the population, in the supply of clean water and in the effective disposal of excreta, rather than to specific medical interventions is not to downplay the role of the medical profession in achieving these successes. In many cases, it was physicians who saw the relationship between illness and nutrition, water supply, sanitation and poverty, and forced the authorities to take action (Rosen, 1979). Health professions have played, and continue to play, an important role in changing disease patterns. What is important to recognise, is that the actions to control or eradicate diseases often involve social, economic or environmental interventions (Ziglio et al., 2000).

The holistic approach to health implies that all sectors of society have an effect on health, in particular agriculture, animal husbandry, food industry, education, housing, public works, communications and other sectors (WHO, 1978).

The fundamental conditions and resources for health, according to the Ottawa Charter for Health Promotion (1986) are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in the basic prerequisites.

According to the Adelaide Statement (1988) important prerequisites for health and social development are peace and social justice; nutritious food and



clean water; education and decent housing; a useful role in society and an adequate income; conservation of resources and the protection of the ecosystem.

“Health care lies beyond the traditional health system. Initiatives have to come from all sectors that can contribute to the creation of supportive environments for health, and must be acted upon by people in local communities, nationally by government and non-governmental organisations, and globally through international organisations. Action will predominantly involve such sectors as education, transport, housing and urban development, industrial production and agriculture” (Sundsval Statement, 1991).

The potential of corporate and business interests, non-governmental bodies and community organisations for preserving and promoting people’s health should be encouraged. Trade unions, commerce and industry, academic associations and religious leaders have many opportunities to act in the health interests of the whole community. New alliances must be forged to provide the impetus for health action. The most fundamental challenge for individual nations and international agencies in achieving healthy public policy is to encourage collaboration (or developing partnerships) in peace, human rights and social justice, ecology, and sustainable development around the globe (Adelaide Statement, 1988).

Intersectoral action makes possible the joining of factors, knowledge and the means to understand and solve complex issues whose solutions lie outside the capacity and responsibility of a single sector. It can be both a strategy and a process, and can be used to promote and achieve shared goals in many areas including policy, research, planning, practice and funding. It may take different forms, such as co-operative initiatives, alliances, coalitions or partnerships. According to Health Canada (1999), intersectoral action has two dimensions: a horizontal dimension that links different sectors at a given level (e.g. partners in the health, education and justice sectors at the community level) and a vertical dimension that links different levels within each sector. Both dimensions are important for success.



The current emphasis on intersectoral action to enhance population health is being driven by many factors, particularly a growing consensus about the importance of key determinants of health such as income, education, social support networks, employment and working conditions, which are the purview of many different sectors. They also include the need to reduce persistent health status disparities, our increasing understanding of the conditions which enable effective intersectoral action and a positive climate for action.

### 2.3 Health Promotion: A Global Movement

“The main social target of governments and WHO in the coming decades should be the attainment by all citizens of the world, by the year 2000, of a level of health that will permit them to lead socially and economically productive lives”, stated by the WHO in 1977 at the 30th World Health Assembly (1977). This was the beginning of what has come to be known globally as the “*Health For All Movement*” calling for fundamental changes in the health policy of member countries, including a much higher priority for public health and disease prevention.

This statement led to the Alma-Ata Declaration of the goal of “Health for All by the year 2000”. WHO and UNICEF, at the International Conference on Primary Health Care in Alma-Ata (1978), identified primary health care as the basis of the Global Strategy for Health for All by the Year 2000. “*Primary Health Care is the key to achieving an acceptable level of health throughout the world in the foreseeable future as part of social development and in the spirit of social justice*”. It offers a rational and practical means for both developing and industrialised nations to work towards the goal of ‘health for all’ (WHO-UNICEF, 1978).

This is a result of a world-wide realisation that a predominantly biomedical approach to health and healthcare has had little effect in reducing mortality and morbidity in preventable diseases (McKeowan, 1976).



Most of the reviewed literature acknowledges that the term '*Health Promotion*' was first used in a document written in 1974 by Marc Lalonde, Former Minister of Health and Social Welfare in Canada. The document is called: "*A New Perspective on Health for All Canadians*" (Lalonde, 1974). Its thesis was that national ministries of health are fairly restricted in what they can do to create conditions which so enhance people's sense of self esteem and social effectiveness that they easily adopt attitudes and life-styles which promote health -rather than merely prevent illness. The thesis indicated that something beyond health education was needed if Canada's health problems were to be solved.

The 1974 report on the Health of Canadians emphasising environmental factors, individual biology and life-styles as well as health care services, was regarded as a milestone in the development of health promotion, and preceded the WHO's initiatives in this area. Consequently, health promotion has become an important force in improving the quality and duration of peoples' lives (Catford, 1992).

Nevertheless, Terris (1992) argues that the first use of the term 'health promotion' occurred in 1945, when Henry E. Sigerist, the great medical historian, defined the four major tasks of medicine as: (1) the promotion of health, (2) the prevention of illness, (3) the restoration of the sick, and (4) the rehabilitation (Sigerist cited: Terris, 1992). He (Sigerist) stated that health is promoted by providing a decent standard of living, good labour conditions, education, physical culture and means of rest and recreation and called for the co-ordinated efforts of statesmen, labour, industry, educators, and physicians to this end. Sigerist also noted that the promotion of health obviously tends to prevent illness, yet effective prevention calls for special protective measures such as sanitation and communicable disease control, maternal and child health, and occupational health.

Over recent years, a number of steps have been taken towards identifying global health concerns, and the process by which the international promotion of health and well-being can be realised. The WHO seeks to achieve a 'new public health' through political action.



### 2.3.1 Ottawa Charter for Health Promotion

The first step of the global acceptance of health promotion was an international conference held in Ottawa, Canada, in 1986. In the words of the Ottawa Charter for Health Promotion (1986), WHO identified five health promotion action areas. They are:

***Building healthy public policy:*** Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organisational change. It is a co-ordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments. Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

***Creating supportive environments:*** Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health. The overall guiding principle for the world -nations, regions and communities alike- is the need to encourage reciprocal maintenance – to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasised as a global responsibility. Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organises health should help to create a healthy society. Health promotion seeks to generate living and working conditions that are safe, satisfying and enjoyable. Systematic assessment of the health impact of a rapidly changing



environment -particularly in areas of technology, work, energy production and urbanisation- is essential, and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environment and the conservation of natural resources must be addressed in any health promotion strategy.

***Strengthening community action:*** Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities – their ownership and control of their own endeavours and destinies. Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in the direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

***Developing personal skills:*** Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health. Enabling people to learn, throughout life, to prepare themselves for all of stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

***Reorienting health services:*** The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health. The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respect cultural needs. This



mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components. Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organisation of health services which refocus on the total needs of the individual as a whole person.

### **2.3.2 Adelaide Recommendations for Healthy Public Policy**

In 1988, the second international conference on health promotion was convened in Adelaide, Australia, to address “Building Healthy Public Policy”, (Adelaide Statement, 1988). The healthy public policy establishes the environment that makes the other four areas of action identified by Ottawa Charter possible.

According to the conference statement, healthy public policy is characterised by an explicit concern for health and equity in all areas of policy, and accountability for their impact on health. The main aim of a healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes health choices possible, or easier, for citizens. It makes social and physical environments health enhancing. In the pursuit of healthy public policy, government sectors concerned with agriculture, trade, education, industry, and communications need to take into account health as an essential factor when formulating policy. These sectors should be accountable for the health consequences of their policy decisions. They should pay as much attention to health as to economic considerations.

Health is both a fundamental human right and a sound social investment. Governments need to invest resources in healthy public policy and health promotion in order to raise the health status of all their citizens. A basic principle for social justice is to ensure that people have access to the essentials for a healthy and satisfying life. At the same time, this raises overall societal productivity in both



social and economic terms. Healthy public policy in the short term will lead to long term economic benefits.

The commitment to healthy public policy demands an approach that emphasises consultation and negotiation. Healthy public policy requires strong advocates who put health high in the agenda of policy makers. This means fostering the work of advocacy groups and helping the media to interpret complex policy issues.

Educational institutes must respond to the emerging needs of the new public health by reorienting existing curricula to include enabling, mediating, and advocating skills. There must be a power shift from control to technical support in policy development. In addition, forums for the exchange of experiences at local, national and international levels are needed.

This conference identified four key areas as priorities for healthy public policy for immediate action. They are: supporting the health of women; food and nutrition; tobacco and alcohol; and creating supportive environments.

A subsequent conference on **Health Promotion in Developing Countries: a Call for Action** in Geneva (1989) has further developed the relevance and meaning of health promotion. “A Call for Action” underlines the role of health promotion in creating and constantly reinforcing conditions that encourage people to make wise health choices and enable them to live healthy lives (WHO, 1990).

### **2.3.3 Sundsvall Statement on Supportive Environments for Health**

Creating Supportive Environments was the theme of the Third International Conference on Health Promotion which was held in Sundsvall, Sweden, in 1991. The term ‘environment’, as used here, is considered in its broadest sense and encompasses the social, political, economic and cultural environments, as well as the physical one (Sundsvall Statement, 1991).



This statement believes that proposals to implement the Health for All strategies must reflect two basic principles; a) equity must be a basic priority in creating supportive environments for health, and b) public action for supportive environments for health must recognise the interdependence of all living beings, and must manage all natural resources, taking into account the needs of future generations.

The statement identified four key public health action strategies to promote the creation of supportive environments at community level:

1. Strengthening advocacy through community action, particularly through groups organised by women.
2. Enabling communities and individuals to take control over their health and environment through education and empowerment.
3. Building alliances for health and supportive environments in order to strengthen the co-operation between health and environmental campaigns and strategies.
4. Mediating between conflicting interests in society in order to ensure equitable access to supportive environments for health.

The theme of the **XVth World Conference of the International Union for Health Promotion and Education (IUHPE)** -formerly International Union of Health Education (IUHE)- held in 1995 in Japan, was “*Bringing Health to Life*”. Dr. Rajala, President of IUHPE at that time, said at this conference: “A positive state of health, which is made possible by available human knowledge and resources, is the right of everybody. The objective can be reached through the joint efforts of all sectors of society in health promoting activities and by each citizen increasing his/her own activity in promoting their own and other’s health” (Rajala, 1995).



### 2.3.4 Jakarta Declaration on Leading Health Promotion into the 21<sup>st</sup> Century

Jakarta, the capital of Indonesia, hosted in 1997 the Fourth International Conference on Health Promotion. The theme of this conference was “New Players for a New Era: Leading Health Promotion into the 21<sup>st</sup> Century”. The outcomes of this conference formed the basis of “Jakarta Declaration” (1997).

It outlined five priorities for health promotion in the 21<sup>st</sup> century. They are:

***Promoting social responsibility for health:*** Decision-makers must be firmly committed to social responsibility. Both public and private sectors should promote health by pursuing policies and practices that:

1. avoid harming the health of individuals,
2. protect the environment and ensure sustainable use of resources,
3. restrict the production of, and trade in, inherently harmful goods and substances such as tobacco and armaments, as well as discourage unhealthy marketing practices,
4. safeguard both the citizen in the marketplace and the individual in the workplace,
5. include equity-focused health impact assessments as an integral part of policy development.

***Increasing investments for health development:*** In many countries, current investment in health is inadequate and often ineffective. Increasing investment for health development requires a truly multisectoral approach including, for example, additional resources for education and housing as well as for the health sector. Greater investment for health and reorientation of existing investments, both within and among countries, has the potential to achieve significant advances in human development, health and quality of life.

Investments for health should reflect the needs of particular groups such as women, children, older people, and indigenous, poor and marginalised populations.



***Consolidating and expanding partnerships for health:*** Health promotion requires partnerships for health and social developments between different sectors, at all levels of governance and society. Existing partnerships need to be strengthened and the potential for new partnerships must be explored.

Partnerships offer mutual benefit for health through the sharing of expertise, skills and resources. Each partnership must be transparent and accountable and be based on agreed ethical principles, mutual understanding and respect. WHO guidelines should be adhered to.

***Increasing community capacity and empowering the individual:*** Health promotion is carried out **by and with** people, not **on or to** people. It improves both, the ability of individuals to take action, and the capacity of groups, organisations or communities to influence the determinants of health.

Improving the capacity of communities for health promotion requires practical education, leadership training, and access to resources. Empowering individuals demands more consistent, reliable access to the decision making process and the skills and knowledge essential to effect change.

Both traditional communication and the new information media support this process. Social, cultural and spiritual resources need to be harnessed in innovative ways.

***Securing an infrastructure for health promotion:*** To secure an infrastructure for health promotion, new mechanisms for funding it locally, nationally and globally must be found. Incentives should be developed to influence the actions of governments, non-governmental organisations, educational institutions and the private sector to make sure that resource mobilisation for health promotion is maximised.



"Setting for health" represent the organisational base of the infrastructure required for health promotion. New health challenges mean that new and diverse networks need to be created to achieve intersectoral collaboration. Such networks should provide mutual assistance within and among countries and facilitate exchange of information on which strategies have proved effective, and in which settings.

Training in, and practice of, local leadership skills should be encouraged in order to support health promotion activities. Documentation of experiences in health promotion through research and project reporting should be enhanced to improve planning, implementation and evaluation.

All countries should develop the appropriate political, legal, educational, social and economic environments required to support health promotion.

The author attended the **XVth World Conference on Health Promotion and Health Education**, organised by the IUHPE and co-sponsored by WHO, held in Puerto Rico, at which a piece of this research was presented. Mr. Spencer Hagard, President of IUHPE, said in his speech entitled 'New horizons in health – from vision to practice': "We can either look forward to a dialogue of the deaf, or we shall need to engage decision-makers in our thinking, and persuade them of our arguments. We shall need to communicate a vision of health which responds to the predominant agenda. To move the great levers of the modern world, we need to strongly direct our attention to those who formulate and implement the world's social and economic policies" (Hagard, 1998). Dr. Desmond O'Bryne, Chief, Health Education and Health Promotion, WHO Headquarters, said at this conference "We are at the crossroads of the millennium, at a time for reflection and a time for change. It is not only the speed of change which has an impact on health; it is also the diversity and complex interdependence of the many global trends now influencing the health status of the world. Although the 21<sup>st</sup> century brings new threats, it also brings new approaches and opportunities to overcome them. Change provide opportunity. It is an opportunity for health promotion to be proactive and meet the challengers" (WHO, 1998).



### 2.3.5 Mexico Ministerial Statement for Health Promotion

The Fifth Global Conference on Health Promotion under the theme “Health Promotion: Bridging the Equity Gap” was held during June 5-9, this year, in Mexico City. The author was invited to this conference as a technical delegate and to present his project on evaluating the role of the National Programme of Health Education in promoting the health of the Libyan community, as a selected example for evaluating countries’ strategies for health promotion.

The Mexico Ministerial Statement for Health Promotion (2000) built upon the developments following four previous international health promotion conferences. It considered the resources and structures needed to develop and sustain capacity for health promotion at local, national and international levels. These are:

***Strengthening the "science and art" of health promotion:*** It was quite clear from the technical discussions and ministerial meetings that continued efforts need to be made to strengthen "the evidence-base" on which health promotion policies and practices are based by including all forms of evidence that are derived from the full range of experiential knowledge. In addition, this evidence needs to be better disseminated through improved exchanges of information within and between countries. Finally, it was clear that this evidence has to be communicated in ways that are politically, socially and culturally relevant to countries and communities.

This will require:

- continued investment in appropriate research and evaluation to improve understanding of the determinants of health, and the effectiveness of health promotion strategies to address these determinants. This will require a broad range of research methods which reflect the values, processes and intended outcomes of health promotion policies and practices.
- the development of indicators which are more sensitive and relevant to health (as opposed to disease), health determinants, equity in health, and the



short term impact of particular health promotion strategies and processes of change.

- **improved interaction, co-operation, and participation** among researches, policy-makers, practitioners, and the communities with whom they work. Through improved interaction there is a greater chance that researchers will answer questions that are valued and valuable for decision making, and that policy-makers and practitioners will make greater use of research findings.
- **identification of practical strategies** that can be employed to better **locate, assemble, synthesise and communicate findings from research ongoing evaluation**, and experiences from case studies. This can be achieved in a variety of ways using established methods such as through conferences and grass-roots networks, and publication in journals, as well as making use of newer technologies, including the internet
- **greater attention to opportunities to communicate evidence in ways that are socially and politically relevant.** This has to do, in part, with the timing and orientation of the presentation of evidence.

The case studies presented at the Conference were testimony to the extraordinary spirit, creativity and resourcefulness of practitioners and activists, mostly operating at a community level. Processes which develop practical skills and capacities for health promotion, which encourage leadership for health, and which support the emergence of social entrepreneurs in communities, are vital for the continued development and implementation of health promotion ideas and actions. This will require:

- (i) solidarity,
- (ii) mobilisation of resources,
- (iii) development of community capacity,
- (iv) development of human resources, and
- (v) creation of networks and associations of practitioners.



***Strengthening political skills and actions for health promotion:*** A strong and consistent theme of the technical meetings concerned the need to work with and through existing political systems and structures to ensure healthy public policy, adequate investment in health, and facilitation of an adequate infrastructure for health promotion. This will require:

- **democratic processes** which emphasise decentralisation of power, resources and responsibilities for health.
- **continued social and political activism** where this is needed to influence government policies and to strengthen the powers and responsibilities of communities to determine their own health
- **use of a system of equity-oriented health impact assessment** particularly of public policies at all levels of government, and of private sector policies and practices. This is a concrete mechanism to underpin inter-sectoral action for health, and to support social responsibilities for health among both governments, the private sector, NGOs and communities.
- **re-orientation of health services** towards health promotion and primary prevention, and to towards achieving greater equity in health. A "second wave" of health sector reform may offer an important window of opportunity to achieve this change
- **improved interactions** between politicians, policy-makers, researchers and practitioners. From this it will be more likely that on the one hand, health promotion actions are informed by and responsive to prevailing political realities and scientific advances, and on the other, the importance of investing for health, and in health promotion, is well communicated and widely understood.
- **Plans and structures** which strengthen the existing **capacity for implementing health promotion strategies**, and support **synergies between different levels** (local, national & international). These structures may be supported by governments, NGOs or the private sector. The framework for countrywide plans of action for health promotion -which will be explained in chapter three- may be helpful in guiding these actions.



## 2.4 Health Promotion- Description and Approaches

The term 'health promotion' is regarded by Fisher and his colleagues (1986) as synonymous with the term 'public health'. The author disagrees with this, as he sees the term 'health promotion' as constituting a dynamic and interactive process based on person-empowerment, whereas 'public health' focuses on the crucial issue of health-engendering social structures. Vernon (1996) and others consider health promotion as 'a new public health'.

Tannahill (1988) says health promotion and primary care may be seen as 'twin pillars' of the Health for All strategy. Health promotion is frequently described as a new discipline; this is not so (Naidoo & Wills, 1994; MacDonald, 1996a). It has evolved from health education, which has its roots in the classic Greek view of health. This view is holistic and is described as the degree to which individuals are capable of achieving balance and harmony in their lives (Vernon, 1996). However, the term 'health promotion' itself is of relatively recent origin (Dines & Cribb, 1982).

There has been much debate since the 1980s on the use of the terms health promotion and health education. Health education is seen as a very important element in health promotion, it is one route to the improvement of people's health, encompassing all those activities which aim to provide health via learning of one kind or another.

Health promotion, partly by contrast, is seen as a general term which includes health education and other proactive aspects of health. Health promotion is a wider ranging term: that is it is health education 'plus', (Tannahill, 1985).

Kickbusch (1996) considers health promotion to have emerged from health education. He sees many reasons for this, two in particular are: first, health educators became more aware of the need for positive approaches in health education such as enhancing health and creating health potential, rather than



focusing on disease prevention; second, it became self-evident that health education could only develop its full potential if it was supported by structural measures such as legal, environmental and regulatory actions.

The 1979 report by the U.S Public Health Service in its book “Healthy People: The Surgeon-Generals’ Report on Health Promotion and Disease Prevention” (1979) separates health promotion from disease prevention and gave it equal status. Health promotion was defined in terms of life-style changes, and prevention was defined as protection from environmental threats to health.

Nutbeam (1986) in his health promotion glossary, also distinguishes health promotion from disease prevention, the two being separate but complementary activities which overlap in a variety of situations and circumstances. He writes: “Disease prevention is essentially an activity in the medical field dealing with individuals or particularly defined groups at risk; it aims to conserve health. It does not represent a positive conception of health that moves ahead, but is concerned with maintaining (and protecting) health status. Health promotion, on the other hand, starts out by considering the whole population in the context of their everyday lives, not selected individuals or groups. Its goal is to enhance health”.

Terris (1992) comments that separating health promotion from disease prevention and giving them apparently equal status, has encouraged a variety of interpretations of the role of health promotion. Some conceived the term to cover all health services; others, as a synonym for prevention; and still others, as an area to which prevention is subordinate.

The WHO attempts to separate health promotion from medical education, preventive medicine and health protection (Dines & Cribb, 1993). Its overarching vademecum for achieving these goals is through empowerment (MacDonald, 1994).

The form of healthcare now advocated by the WHO is one based on an ecological systems model. As such, hospital-based medical care is seen only as part



of a healthcare system that is combined with aspects of environmental health protection, personal prevention and primary healthcare. Traditionally, the biomedical model of healthcare has been dominant in the education of everyone in the caring professions. However, because of the change in emphasis from intervention to prevention, health promotion is one of the disciplines that are now thought to be essential in the education of a new generation of health professionals (Vernon, 1996).

Tones (1985) recognises the possibility of examining the nature of health promotion from first principles, when he writes: 'At one level of analysis the notion of health promotion must logically refer to any activity designed to foster health'.

Dennis and colleagues (1982) and MacDonald (1993) appear to adopt a similar concept when suggesting 'health promotion covers all aspects of those activities that seek to improve the health status of individuals and communities'. According to Tannahill's model; health promotion is an umbrella term for three elements; health education, preventive medicine and health protection (Tannahill, 1985).

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health promotion. Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men (Ottawa Charter for Health Promotion, 1986)



MacDonald (1994) argues that health promotion is a revolutionary idea that requires a critically examined basis for moral and political social changes. Green & Kreuter (1991) define health promotion as the combination of educational and environmental supports for actions and conditions of living conducive to health. WHO (1994) describes health promotion as social, educational and political action that enhances public awareness of health, fosters healthy life-styles and community action in support of health, and empowers people to exercise their rights and responsibilities in shaping environments, systems and policies that are conducive to health and well-being. Health promotion is, in fact, enlightened health activism; it is a process of activating communities, policy-makers, professionals and the public in favour of health-supportive policies, systems and ways of living. It is carried out through acts of advocacy, empowerment of people and the building of social support systems that enable people to make healthy choices and live healthy lives.

Lily Walker -the famous Australian Aborigine commentator- said in this context: 'If you come here to help me, you're wasting your time. But if you come here because your liberation -your health-is bound up in mine, then let us begin' (Labonte, 1997).

The WHO definitions of health promotion neatly encompass this: "*Health promotion is the process of enabling people to increase control over and to improve their health*" (WHO, 1984). It is a concept that can revitalise primary health care approaches in both developing and industrialised nations (WHO, 1994). This is just as well, because its epistemology is such that it cannot be 'national' (Lalonde, 1974). It must be global. One could say: "Think globally and act locally".

Early attempts to classify approaches to health promotion were made by health educationalists who wished to demonstrate the shift from individual to collective and societal action to improve health (Vernon, 1996). The most relevant one is that by Ewles and Simnett (1996), who described five approaches to health promotion;



- 1-Medical; to prevent or ameliorate ill-health, in order to achieve freedom from medically defined disease.
- 2-Behaviour change; to adopt healthy life-styles and change attitudes and behaviour.
- 3-Educational; to impart knowledge and act on well-informed decisions.
- 4-Client Centred; to enable people to make their own decisions and choices according to their own value systems.
- 5-Societal change; to help people take control over their own lives and make choice easier to change the environment.

The clinical practice of health promotion is based on at least four assumptions: (a) that behaviours increase the risk of certain chronic diseases, (b) that changes in behaviours can reduce the probability of risk of certain diseases, (c) that behaviour can be easily changed, and (d) that behavioural interventions are cost effective (Kaplan, 1984).

“A Discussion Document on the Concept and Principles of Health Promotion” called *‘the Yellow Document’* was produced in 1984 to mark the start of health promotion programme in the European office of the WHO (1984).

Five major principles of health promotion were put forward:

1. Health promotion involves the population as a whole in the context of people’s every day lives, rather than focusing on those at risk of specific diseases.
2. Health promotion is directed towards action on the determinants or causes of health.
3. Health promotion combines diverse, but complementary, methods or approaches.
4. Health promotion aims particularly at effective and concrete public participation.
5. Health professionals, particularly in primary health care, have an important role in nurturing and enabling health promotion.



Five subject areas were stated in this document. They are:

1. Access to health.
2. Development of an environment conducive to health.
3. Strengthening of social networks and social supports.
4. Promoting positive health behaviour and appropriate coping strategies as a key aim in health promotion.
5. Increasing knowledge and disseminating information related health.

## **2.5 Health Education is the Heart of Health Promotion Strategy**

Health education is rather an abstract term meaning different things to different people. To some, it is a matter of public relations aimed at publicising the activities of health departments. Some consider it synonymous with health propaganda. Many equate it with transmission of information about health and disease from the expert professional to the lay client (WHO, 1975).

People have the need for and the right to information on how to maintain, protect and promote health. Giving people the information and ability to make a choice must therefore be an essential and important component of the health for all strategy (WHO, 1994).

Health Education comes at the top of the eight essential elements of primary health care - stated by The Declaration of Alma-Ata - which include; Promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against major infectious diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs (WHO-UNICEF, 1978). Thus health education is a cornerstone of primary health care and an essential component of any strategy to improve the health of people in developing and developed countries (Hubley, 1993). It is neither synonymous with health promotion (Tones, 1996), nor necessarily always in harmony with it (MacDonald, 1996b). However, it has a central role in the promotion of health (French, 1990).



Clearly, Downie and colleagues (1991) see health education as being the core of health promotion and not part of an evolutionary process.

Health education of the public began as a discipline of public health in the early decades of this century. It received further impetus during the Second World War, when added emphasis was placed on efforts to inform people about better nutrition and related health problems. Today, there is a wide recognition of the need for education of the public on health matters, so that people may take better care of their own health and initiate health support activities for their community (WHO, 1994).

The process began initially by offering publicity and information about topics such as diet and personal hygiene, then gradually progressed to more comprehensive health education directed at fostering behaviour change and community action for health. At first, such efforts in developing countries focused on specific health problems, such as hookworm control in the 1930s, safe water and basic sanitation projects in the 1940s and 1950s, and family planning more recently.

In the late 1970s, while regional variations persisted, health education units were established in many countries throughout the world. Many of the industrialised countries established these units either within their health ministries or as semi-independent centres or bureaux, wholly or in part funded by them. For example, the United Kingdom established centres in England, Scotland and Wales; France, Germany (the pre-unification Federal Republic), Ireland and Netherlands had national centres; Canada had a strong centre within the (then) Department of Health and welfare. The countries of the former USSR also had similar government-funded centralised health education units (WHO, 1998a).

Developing countries in general gave the responsibility for health education either to a particular unit within the ministry of health and/or to a particular person. In many cases, such a unit or person had many other responsibilities and very limited resources. There was an ongoing need for training and development at all



levels (WHO, 1998a).

Only gradually have health education programmes started taking a holistic view of health (WHO, 1994). The WHO Seventh General Programme of World Health covering the period 1984 to 1989, indicated that the role of information, education and communication for health would be even more prominent (WHO, 1983).

Today, health education is needed more than ever to ensure that individuals and communities work together to develop relevant and affordable interventions and strategies for health and social development. Dr. Hiroshi Nakajima, the Former Director General of the WHO, said in the IUHPE's XVth World Conference (1995): 'This broad approach, through health promotion and health education, will help us to bridge the gaps in terms of health, both between and within countries'.

Early health education efforts were largely limited to the use of printed materials, posters and audio-visual aids. Interpersonal communication was confined to home visits and patient education in clinics. The situation has changed dramatically over the years. Multifaceted strategies have been designed and applied, with emphasis on community organisation, group discussion and public debate, often involving the mass media (TV, radio and press). At the same time, the scale of operations in health education has expanded (Kemmm & Close, 1995; WHO, 1994).

Health education used to be seen as concerned mainly with personal health actions. It was perceived as a series of messages about healthy habits and the avoidance of risk behaviour. Though these kinds of health messages remain important today and should not be neglected, it is equally important to direct education towards collective action, (WHO, 1994). Empowering people to take responsibility for collective health is a challenge that has to be met (Wallerstein, 1992; WHO, 1994).



Health education can be regarded as: The communication of knowledge and the provision of experiences to help individuals to develop attitudes and skills which will assist their adopting behaviours to improve and maintain health for themselves and their fellows. Health education aims to assist individuals, groups and communities to make informed decisions about their health. In addition, it aims to enable individuals and groups to influence change in social policy (Fisher et al., 1986; WHO, 1988; Minkler, 1994).

The WHO-IUHE definition of health education distils the essential elements of health education: *Health education is the combination of planned social action and planned learning experience designed to enable people to gain control over the determinants of health... and of health behaviour... and the social conditions that affect their health status and the health status of others* (IUHE, 1991).

## **2.6 Levels, Approaches and Orientations of Health Education**

Health education is a multi-disciplinary activity involving a variety of purposes, methods and channels of delivery. A large number of classifications and models of health education have been put forward in recent years. The most relevant ones to my work have been the following;

### **2.6.1 Levels of health education**

According to Fisher and colleagues (1986), the purposes of health education can be conveniently categorised in three levels: Primary prevention, secondary prevention and tertiary prevention, with the emphasis placed on primary prevention.

*Primary level health education* is directed at healthy people, and aims to help individuals or groups learn how to keep healthy and how to prevent the onset of disease and disability. Health education for primary prevention encourages people to develop behaviour conducive to good health. Primary prevention is the level at which health education is able to encompass its role and function, not only



to influence individual behaviour change but also to influence group and community action, such as to alter environmental, economic and organisational supports for health.

*Secondary level health education* aims to assist individuals to recognise symptoms of diseases, and, by identifying the early onset of illness, to enable them to seek measures to reverse or control the problem. Secondary prevention helps to reduce the prevalence of morbidity by shortening the duration of illness or by reducing the prevalence of screening occurring in the pre-morbid phase of disease.

*Tertiary level health education* is generally regarded as self-care education or patient education. The target groups are people with identifiable diseases, illnesses and injuries. Many of these conditions can be treated or controlled through personal and family self-care, independent of professional medical sources. The main purpose of tertiary health education is to help people learn about their illnesses, treatments and available health services, so that there is a reduced chance of recurrences or relapses (Fisher et al, 1986).

### **2.6.2 Approaches to health education**

According to Tones and colleagues (1990), health education approaches are:

*The Preventive Model*; adopts behaviours which will prevent disease at primary, secondary or tertiary levels.

*Radical-Political Model*; is concerned with achieving social and environmental change by triggering political action.

*Self-Empowerment Model*; seeks to facilitate choice, not merely by providing understanding, value clarification and practice in decision making, but by attempting to empower the individual.



### 2.6.3 Orientations of health education

In the search for a solid health education foundation for health promotion planning, it is helpful to distinguish and assess three categories of health education: disease-oriented, risk factor-oriented, and health-oriented (Tannahill, 1990; Downie et al., 1996).

*Disease-oriented health education;* Despite improvements in the 1990s, this type of health education is still commonly endorsed, explicitly or implicitly, by politicians, epidemiologists, and health service managers. Efforts are aimed at the prevention of specific diseases, and there is much emphasis on gauging success in terms of progress towards target rates of morbidity and mortality. The inherent assumption is that major preventable diseases, such as cardiovascular disorders and malignancies, are best dealt with by specific preventive programmes aimed at reducing relevant 'risk factors'.

The focus is thus negative. People are expected to look after themselves in the light of anti-cancer 'campaigns' and the like. In fact, this kind of approach is of limited educational value. Whilst it is true that people who are already primed to make changes, such as stopping smoking or cutting down on alcohol, may well do so as a result of anti-tobacco or anti-alcohol publicity or advice, it is arguably unrealistic to expect wholesale changes in life-style as a result of purely negatively focused education.

In this approach of formulating health education programmes, individuals or groups work on single topics in relative, or even absolute, isolation from one another. Most fundamentally, the disease-oriented model is unacceptably deficient in its incomplete view of health, not only in neglecting social and collective aspects but also in ignoring the positive dimension -active participation for improving the quality of life, of which health is an essential component, embracing well-being and fitness- is neglected.



*Risk factor-oriented health education;* This is aimed at eliminating particular risk factors in order to prevent associated diseases. Much health education is currently focused in this way. The main advantage of this approach over disease-orientation is the recognition that a single risk factor can be linked to more than one disease category. Thus, although the model is still an incrementalist one, there are fewer problems with duplication and confusion.

However, the model is open to the other criticisms levelled at disease-oriented health education: the view of health is inadequate; educational interaction is limited; and experts dominate.

*Health-oriented health education;* In this, there is a dual focus: the aim is to enhance positive health as well as to prevent ill-health. The physical, mental, and social components of both of these dimensions of health are recognised. This is not to deny the importance and motivating qualities of preventive benefits. It is simply an acknowledgement that the incorporation of a positive focus enhances educational validity.

This model avoids the pitfalls of the first two orientations. The major organisational and communication problems of disease- and risk factor-oriented health education are overcome by setting as priorities people and places, in which they may be reached (rather than the diseases and the risk factors). Effort is directed towards developing comprehensive programmes of health education in key community settings and with key people. These key settings and groups are determined locally, with sensitivity to public opinion. Multidisciplinary and intersectoral collaboration is facilitated. Programmes can thus be properly coordinated, cutting out inefficient and ineffective duplication. Moreover, content, timing and methodology can be tailored to the needs and characteristics of the particular setting or group.

Obviously, the health-oriented approach should be the preferred model for planning health education.



## 2.7 Models of Human Behaviour Change used in Health Education

Social scientists have evolved a number of models to explain the process of change influenced by personal and interpersonal communications within an individual. Stage models view behaviour change as a series of actions or events. These models allow researchers to detect movement towards a behaviour change among people who have not yet attained it. In addition, investigators can see the influence of factors at the beginning and throughout the change process, rather than expecting all factors to influence the end product of actual behaviour change or adoption (Prochaska et al., 1992).

According to Weinstein (1988), a stage theory suggests that (a) people at different stages in the change process behave in qualitatively distinct ways, and (b) the interventions needed to move people towards the desired behaviours vary stage by stage. Thus, an effective programme (*or medium*) in one situation may be inappropriate in another (Catania et al., 1990 & Prochaska et al., 1992).

In contrast, non-stage theories and models of preventive behaviour view behaviour change or adoption as movement along a single continuum of action. They assume that the relative probability of a person taking action is a mathematical function of that individual's attitudes and beliefs. Which factors are included in this function, how they are weighted, and their interactions are assumed to be constant from the time one learns of a threat to the time action is taken (Weinstein, 1988).

**- The knowledge-attitude-behaviour change model:** This model is widely used in the field of individual behaviour change (Park & Park, 1997). According to this model, people appear to pass through a series of distinguishable stages before they adopt a new practice. These stages are:

*Awareness:* At this stage the individual comes to recognise the new idea or practice. He/she has only some very general information about it and knows little about its usefulness, limitations and applicability to him/her.

*Interest:* This is the stage when the individual seeks more detailed information.



He/she is willing to listen or read or learn more about it.

*Evaluation:* During this stage, the individual weighs the pros and cons of the practice and evaluates its usefulness to him/her or his/her family. Such an evaluation is mental exercise and results in a decision to try the practice or reject it.

*Trial:* This is the stage when the decision is put into practice. He/she would need additional information and help at this stage so as to overcome the problems in implementing the idea.

*Adoption:* At this stage, the individual decides that the new practice is good and adopts it.

Hubley (1993) identified similar stages for a successful communication. They are: (1) reaching the intended audience; (2) attracting the audience's attention; (3) understanding the message 'perception'; (4) promoting change 'acceptance' (5) producing a change in behaviour; and (6) improvement in health.

- **The transtheoretical model or the stages of change theory:** This is a similar model to the one described above, used to explain the process of change. (Prochaska & DiClemente, 1983). This model is extensively tested and a wealth of empirical data supports it (Holtgrave et al., 1995). The stages of change in this model include; *Pre-contemplation*, not recognising the problem or the need to change; *Contemplation*, seriously thinking about the problem and the possibility of change; *Preparation*, making a commitment to change and taking steps to prepare for that change; *Action*, successful modification of behaviour for a period of one day to six months; and *Maintenance*, continuation of change from six months to an indefinite period. Research has shown that relapse and recycling through the stages of behaviour change happens often as individuals try to stop or change particular behaviours. Therefore, the original model of linear progression through the stages was modified to a spiral model. The factors and processes that help individuals progress through the stages of behaviour change vary from one stage to another (Prochaska et al., 1992).

These stages of change have been documented with individuals undergoing behaviour change in the areas of smoking cessation, substance use, weight control,



sun screen use, and most recently in the area of condom use (Maibach & Parrott, 1995).

**- The social learning model or social cognitive theory:** The above mentioned stages are not necessarily rigidly sequential and there may be skipping of the stages. The social learning model explains behavioural changes through a different approach (Alcalay, 1983). It is possible to change behaviour without previously having modified attitudes. Furthermore, this model proposes that behaviour change may cause a change in attitudes. This perspective maintains that in order to act in a different way, individuals should learn new behaviours. These new behaviours, in turn, will bring about beneficial consequences for the individual which will induce a continuation of such behaviour in future.

This model describes human behaviour as being reciprocally determined by internal personal factors and the environment in which a person lives (Bandura, 1986). The social cognitive perspective on health behaviour change is, that individual behaviour change can be facilitated by modifying people's personal factors and altering environmental factors to encourage healthy behaviour.

**- The cognitive-dissonance model:** This model is based on the fact that creating dissonance (conflicting beliefs or incentives), and then providing the recommended healthy behaviour as a way of reducing dissonance, may constitute a relevant communication strategy in some cases. The psychological explanation for this is that people seek internal consistency between their beliefs, attitudes and behaviours, and that inconsistency is a psychologically uncomfortable state that leads to efforts to avoid or eliminate inconsistencies (Festinger, 1957). This model is concerned with the nature of the relations between various beliefs or 'cognitions'. Epistemology leads us to appreciate that beliefs, or even cognitions may be unrelated, consistent (consonant), or inconsistent (dissonant, i.e. in conflict). The model states that persons experiencing dissonance will attempt to reduce it, and people will attempt to avoid the experience anyway. Efforts to reduce dissonance will vary according to the degree of dissonance experienced. Dissonance can be reduced in a number of ways; by adding new beliefs to one or



other set; by altering beliefs; or by altering the importance of the beliefs or the importance of the issue *per se*.

- **The health-belief model (Rosenstock, 1974):** The principal of this model is the way in which an individual perceives the world and how these perceptions motivate his/her behaviour. It postulates that readiness to take action for health stems from an individual's perception of his/her susceptibility to disease and its potential severity. Health-related action, then, is hypothesised to depend upon the simultaneous occurrence of three classes of action:

- the extent of sufficient motivation (or health concern) to make health issues relevant;
- the belief that one is susceptible (vulnerable) to a serious health problem (i.e., the perceived threat); and
- the belief that doing something would reduce the perceived threat at a subjective acceptable cost.

- **The protection-motivation theory:** This theory was developed by Rogers (1975) as a model of fear arousal to explain the motivational effect of fear or anxiety resulting from threat communications. The theory assumes that people are motivated to protect themselves not only from physical threats, but also from social and psychological threats.

The theory postulates four mental processes that appraise the presented health information, or threat, and mediate attitudinal and behavioural change:

- the perceived severity of the threatened harmful event;
- the perceived likelihood that the threatened outcome will occur (i.e., the perceived vulnerability).
- the perceived effectiveness of the promoted healthy alternative to avoid the occurrence of the threat (i.e., response efficacy).
- The individual's self perceived ability to perform the recommended healthy alternative (i.e., self efficacy).



- **The theory of reasoned action:** Fishbein and Ajzen (1975) propose in this approach that behaviour is predicted by one's intention to perform the behaviour. Intention, in turn, is a function of personal attitude towards that impending behaviour and attitudes of friends, work colleagues and relatives. According to this theory, attitude is a function of beliefs about the consequences of the behaviour weighted by an evaluation of the importance of the outcome. It is also a function of expectations of significant others weighted by the motivation to conform.

The theory has two important features;

- 1- there is a clear distinction between attitudes towards objects, issues and events *per se*; and attitudes towards behaving in a certain way towards these objects, issues and events.
- 2- there is a clear distinction between the individual's beliefs related to the object or issues *per se*; and the individual's beliefs about what other people think about the issue, and how others think he/she should behave towards the issue (normative beliefs).

- **The theory of trying:** In this theory Bogazzi & Warshaw (1990) focus on the individual's goals rather than on reasoned behaviour choices, and hence is directly applicable to health promotion. It separates trying to achieve the goals from actual attainment of the goals.

- **McGuire's social inoculation model:** McGuire (1970) explains in this model another approach for behaviour change. It is based on an analogy with the process of developing a biological resistance to a disease. This model is concerned with the individual resistance to social pressure towards harmful behaviours.

- **Maslow's hierarchy of needs:** According to Maslow (1968), behaviour is motivated by a hierarchy of human needs. At the base of this is the desire to satisfy physiological needs (life's sustainers such as food, water, oxygen and sleep). Once these are met, safety needs are next in the hierarchy, including the need for protection from harm and alleviation of physical threat. Belongings and love come next and, once these are satisfied, the need for self-esteem emerges as a primary



motivator. This theory clarifies why people may not respond to obviously beneficial and well-meaning interventions. Health needs, in this case, may be compromised for the sake of satisfaction of lower-order needs before health promotion goals can be met.

## **2.8 Health Promotion in Developing & Developed Countries: Different National Policies and Programmes for the same Global Target**

“ Health can not be possessed, it can only be shared. There is no health for me without there being health for my brother and there is no health for Britain without a similar availability for Bangladesh”, Michael Wilson said (1976). The British Government’s efforts to legislate for the preservation of the ozone layer are in vain if other nations do not do so. Clearly, health promotion must be mediated internationally if we are to benefit from it. It is also closely mediated by concepts of personal autonomy and neighbourhood advocacy (MacDonald, 1997). Working for health is both an individual and a societal responsibility (Scott-Samuel, 1997), and involves empowering people to improve their quality of life.

Dr. Nakajima said in this context in the XVth World Conference of IUHPE (1995): “With the globalisation of trade, labour and tourism, and in this age of super-communication highways, no individual, no country and not even any remote village in the world can any longer deem itself immune from problems with which others are confronted. Bringing health to life is the responsibility of us all. Enabling individuals to live healthy and self-fulfilling lives - this, precisely, is bringing health to life, and helping add life to years”. The WHO’s aspiration is to lead global health change towards a more just and a more equitable society, where our ideal goal of ‘Health for All’ can be a reality for all, achieved by all.

The global strategy provides the policy framework for world-wide health action until the turn of the century. The general programmes of work of WHO were envisaged to outline in greater detail the global health policy framework as well as the framework for WHO’s own work. The Seventh General Programme of Work (1984-1989) emphasised the systematic building-up of the infrastructure of



health systems. The Eighth Programme (1990-1995) stressed action at country level. The present Ninth General Programme of Work (1996-2001) is focusing on supporting countries and the international community in concerted, sustained and complementary action to bring about greater equity in health, and to tackle specific health development problems (WHO, 1994).

Countries all over the world are in need of the implementation of an effective primary health care system and an attendant health promotion policy. Varied national circumstances will have a crucial effect on countries' approaches to primary health care and attaining the declared objective for the year 2000 (Health for All). The health "haves" in the affluent countries reflect many differences with the health "have nots" in the developing world. Moreover, these differences are also evident within individual countries, whatever their level of development. Therefore, to meet the needs of their own communities, countries need to implement different policies of effective health promotion to achieve the same target by the year 2000.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners (Ottawa Charter for Health Promotion, 1986).

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account different social, cultural and economic systems (Ottawa Charter for Health Promotion, 1986).

Many countries are implementing Health for All by means of national documents that establish specific goals and targets which purport to make their nation healthier (Baum & Sanders, 1995). However, the immediate needs of countries vary considerably across the world (Fry & Hasler, 1985).



Public health problems vary to a great extent. In many parts of the world, pneumonia, diarrhoea, malaria, measles and malnutrition are still the main killers. In countries where health promotion concepts and ideologies have been primarily developed, the priority health issues are the so called life-style diseases; sexually transmitted diseases, environmental health hazards and mental health problems (Rajala, 1995).

In the UK, one can observe in State documentation a shift of emphasis from prevention of illness and health education to health promotion and primary care (DHHS, 1986). The British government focuses on five key areas for change up to and beyond the year 2000: heart disease and stroke, cancer, mental illness, sexual health, and accidents (DOH, 1992). It also identifies four 'risk factors' or target areas where strategies for change should be focused; these being: smoking, diet and nutrition, blood pressure, and sexual behaviour.

Between 1979 and 1996, the annual budget for health education at national level in the UK trebled in real terms from 8 million pounds to 45 million (Reid, 1996). The most conspicuous elements of health education in the country are the high-profile mass media campaigns mounted by the national health education/promotion agencies and, increasingly, by medical charities and local health promotion services (Downie et al., 1996).

Diarrhoea, malaria, pneumonia, measles and tuberculoses are known to be among the leading causes of death in Nigeria, and the role of health educators is to encourage community participation and work closely with local people so as to plan, implement, and evaluate programmes that will reduce the percentage of those who are not knowledgeable about the causes and symptoms of these diseases (Airhihenbuwa, 1988).

Dehne and Hubley (1993) assessed the health education service in Zimbabwe. They found that there is no existing health education policy, but some service objectives and plans to develop such a service have been stated. Improvements in health status have mainly been due to the success of the service



delivery programmes such as immunisation. Diseases which require behaviour changes have not improved or, in the case of AIDS, it has even worsened. Health education services have evolved from provision of 'village educators' to 'diploma educators'.

Caralaw and colleagues (1980) analysed the pattern of health education development in three Asian countries during their post-colonial period. They found health education services in these countries to be at different stages of professionalisation, developing from a stage at which health education is carried out by 'village educators' with very little professional back-up to an agency run by diploma health educators, and finally to specialist service. However, their study provided little insight into the organisation and management of health education in those countries.

In Cuba, everyone has the right to the care and protection of his/her health. The state guarantees this right: by offering free hospital and medical services, by offering free dental treatment and by developing plans for sanitary efforts, health education, periodic medical examinations, general vaccination, and other preventive medical measures. Children in schools, workers in factories and farms, groups gathered at (local) meetings, etc, are all now thoroughly used to seeing their local Family Health Team, usually involved in some kind of health education activity. The combination of health education and promotion, mediated through the smoothly articulated network of Cuba's Family Doctor Programme, has so far been outstandingly successful in most respects (MacDonald, 1995).

The success of televised health programmes has been well documented in Egypt. The British Medical Journal (1985) concluded that "the lives of more than 100 000 Egyptian children have been saved as a result of what may be the world's most successful health education campaign. This campaign of televised public service announcements advocating oral rehydration therapy for children suffering from diarrhoea (1983-1991) apparently achieved remarkable success (Elkamel, 1995).



During recent decades, a more holistic and intersectoral approach to promoting and protecting health emerged, more so in developed rather in developing countries. Greater emphasis was given to a setting approach to health; as, for example, in the development of healthy cities, health-promoting schools, islands, municipalities and villages, hospitals and workplaces. The settings' approach, as in the case of healthy cities, necessitated the involvement of different sectors, actors within the particular city boundaries, hence promoting greater intersectoral collaboration and health-supportive environments, both physical and social. There are numerous examples of successful healthy cities projects contributing to health promotion, e.g. four cities in Bangladesh, five cities in Nicaragua, healthy cities and villages in Egypt, and various examples of African cities including Dar Es Salaam (WHO, 1998a).

Gradually a more decentralised approach to health education and health promotion developed, with sub-regions or provinces taking on much of the responsibility which was formerly invested in national institutions.

Health promotion, with its emphasis on intersectoral action and settings, provided the framework within which health education remained an important component. Health education institutions/boards were reconstituted to take on the wider responsibility of health promotion. Again, this was mainly confined to developed countries; for instance, Canada, Germany and Australia. Similar new infrastructures and alternative means of resourcing health promotion and health education, such as health promotion foundations, were also established, e.g. the Victoria Health Foundation in Australia (WHO, 1998a).

While training and development diplomas and degrees were provided in developing country regions, many of the developing country personnel travelled outside their region to obtain training and further qualifications. Research, monitoring and evaluation continued to remain very weak in general. This in turn, contributed to poorly planned programmes, loss of valuable experiences and inability to strengthen the status of health education and health promotion.



Many pilot initiatives have not been fully evaluated, nor has their work been reported or published, and many successful ones have not been brought up to scale, either nationally or internationally (WHO, 1998a).

## 2.9 Evaluating Health Promotion and Education

Any field of action in public health, rises above rhetoric only if it can ultimately demonstrate that it can make a difference in public health. Evaluation is at the heart of that demonstration (McQueen, 2000).

Evaluation may be defined as *the process of determining the value or degree of success in achieving predetermined objectives* (Candeias, 1991).

Evaluation of any planned health promotion strategy should not only involve an assessment of outcome but should also consider how that outcome is achieved. However, outcome evaluative research has been the preferred and most common form of assessment for recent major health promotion programmes, because it measures sustained changes which have stood the test of time. Macdonald (1997) and International Union for Health Promotion and Education (1999) mentioned that the outcome of any health promotion intervention is dependent on many inter-related activities and not just the consequence of one particular individual or agency. It could be argued that health education and health promotion led the health care field in terms of evaluative research, largely because in its early days, so much emphasis was placed on justifying resources allocation to such a new era of activity (Nutbeam et al., 1993).

Evaluation of health education programmes should ideally determine whether the programme has succeeded or failed in reaching the intended audience, gaining their attention, being understood, being accepted, resulting in changing behaviour and influencing health (Hubley, 1986; Lefebvre et al., 1995). How successful this programme has been depends, in other words, not so much on



*effectiveness* but rather *efficiency* (Tones, 1990). It should be an integral part of all health promotion activities (Candeias, 1991; Evans et al., 1994).

There is an agreement that health education and health promotion have often been limited to a consideration of the effectiveness of actions and programmes. Nevertheless, since 1996, with the Third European Conference on Health Promotion and Education Effectiveness, many researchers have become interested in “quality assessment” and new ways of thinking have emerged (Deccache, 1997; IUHPE, 1999).

### 2.9.1 Health impact assessment

Health impact assessment (HIA) is the essential tool for healthy policy-making and must therefore be developed and deployed in a form that is acceptable and functional in local communities and their settings (Mittelmark, 2000).

There is no consensus as yet on what exactly HIA should consist of, nor are there any authoritative statements indicating what approaches to HIA are essential if equity is to be in focus. However, in one way or another, all approaches to HIA address the basic question ‘how are existing or planned policies, programmes or projects actually affecting, or likely to affect, people’s health, for good or for bad?’ Answers to this question could help policy makers and programme managers make the decision and changes needed in order to perform their work in the most responsible manner possible (Mittelmark, 2000).

Lehto & Ritsatakis (1999) described a general approach to HIA that has five elements. They are:

- 1) HIA examines *direct* and *indirect* impacts of health strategies, programmes or projects.
- 2) The initial stage is *screening* using available information to determine whether there is confidence that impact is negligible, or if further information is needed.
- 3) If more information is needed, *scoping* is done to determine what level of resources and expertise are required to develop the information.



- 4) Generation of *assessment report*.
- 5) *Modification* of policy/project, if necessary.

### 2.9.2 Evidence-base for health promotion

Evidence can be an outcome of evaluation. Any public policy can be evaluated. Evaluation is a more comprehensive term than evidence. Evaluation carries with it the general notion of assessment; evidence, particularly scientific evidence, implies a strong notion of causality and proof (McQueen, 2000).

A piece of evidence is a fact or datum which is used, or could be used, in making a decision or judgement or in solving a problem. The evidence, when used with the canons of good reasoning and principles of valuation, answers the question “why” when asked for a judgement, decision, or action (Butcher, 1998). The discussion of evidence is not merely a subject for academic debating halls and philosophers of science. Sober reflection shows that the idea of evidence is intimately tied to very pragmatic issues. One needs evidence to take action, allocate funds, solve problems, make informed decisions and build sound policies. Many every day practitioners of health promotion consider the notion of evidence to be at the very heart of today’s health promotion practice.

The randomised controlled trial (RCT) and the quasi-experimental approach are largely creations of a Western literature (McQueen, 2000). These approaches are widely accepted and almost universally applied in the physical and biological sciences; however, in the social and behavioural sciences their acceptance is less universal. Many social sciences, particularly anthropology and sociology, have alternative Western approaches to assessing evidence and the effectiveness of interventions. To the extent that health promotion uses a mixture of approaches, it is therefore difficult to define easily the meaning of an evidence-based approach in health promotion.

Moreover, should health promotion programmes in the developing world simply proceed with the assumption that they will use approaches that have been



shown to meet evidence criteria drawn up in the West? In other human endeavours one does not automatically assume that approaches from the West are necessarily appropriate for the developing world. Should there be a caution in accepting an evidence criterion for health promotion? Alternatively, can developing countries in their search for best practice offer guidance as to how best to evaluate programmes with minimal resources? Would other approaches be useful and/or transportable to those many Western countries with great inequities in population health?

To categorise the strength of a body of evidence on the effectiveness of a specific intervention to impact on a given outcome, a Guide to Community Preventive Services (AJPM, 2000) considered the following factors;

1) suitability of evaluation design to attribute with confidence a change in an outcome by the given intervention, 2) quality of study execution, 3) numbers of studies, 4) consistency of findings, and 5) size of observed effects, and in rare circumstances, 6) expert opinion. Regarding the suitability of evaluation study designs, the guide currently considers studies for which there are concurrent comparison groups and prospective measurements of exposure and outcome (e.g. randomised or non-randomised clinical or community trials, multiple measurement pre/post designs with concurrent comparison groups, prospective cohort studies) as most suitable. All retrospective designs or multiple pre/post measurements but no concurrent comparison groups (e.g. retrospective cohort studies, case-control studies) are considered as moderately suitable. Designs with single pre/post measurements and no concurrent comparison group or exposure and outcomes measured in a single group at the same point in time (e.g. post-only design) are considered by this guide as least suitable.

This guide has noted that population-based prevention strategies are frequently multiple component and complex, and that randomised controlled trials may not be feasible or desirable to evaluate the effectiveness of community interventions. In this guide the term 'evidence' includes: (1) information that is appropriate for answering questions about an intervention effectiveness, (2) the applicability of effectiveness data (i.e., the extent to which available effectiveness data is thought to apply to additional populations and settings), (3) the



intervention's positive or negative side effects (referred to as other effects; including harms and positive or negative non-health outcomes, (4) economic impact, and (5) barriers to implementation of interventions.

The guide decided on the following steps to obtain and evaluate evidence and translate that evidence into recommendations: i) form multidisciplinary chapter development teams; ii) develop a conceptual approach to organising, grouping, and selecting the interventions evaluated in each chapter; iii) select interventions to be evaluated; iv) search for and retrieve evidence; v) assess the quality of and summarise the (body of) evidence of effectiveness; vi) translate evidence of effectiveness into recommendations; vii) consider evidence on applicability, other effects, economic impact, and barriers to implementation; and viii) identify and summarise research gaps (AJPM, 2000).

Many in health promotion recognise that the field is at a critical juncture. There are calls to produce an evidence-based health promotion. Many traditional disciplines in public health have produced their standards for an evidence-based practice. Many of these standards have been adopted in health promotion practice. However, the field of health promotion is too broad to be limited by evidence standards derived from elsewhere (McQueen, 2000). Presently, there is a shortage of evidence regarding the effectiveness of health promotion (IUHPE, 1999: Rootman et al., 2000 *'ready for publication'* cited McQueen, 2000) and a challenge for the new century, for health promotion, is to foster and develop high quality, widely recognised and acceptable standards for evidence-based evaluation (McQueen, 2000).

According to the International Union for Health Promotion and Education (IUHPE) report (1999), evidence in health promotion indicates that: a) comprehensive approaches using all five Ottawa strategies are most effective; b) certain settings such as schools, workplaces, cities and local communities offer practical opportunities for effective health promotion; c) people, including those most affected by health issues, need to be at the heart of health promotion action programmes and decision making processes to ensure real effectiveness; d) real



access to information and education, in appropriate language and styles, is vital; and e) health promotion is a key investment and an essential element of social and economic development.

In May 1998, the Fifty First World Health Assembly urged all Member States to adopt an evidence-based approach to health promotion policy and practice, using the full range of quantitative and qualitative methodologies (WHO, 1998).

### 2.9.3 Limitations to evaluations in health promotion

A group of experts in health promotion evaluation in a document ready for publication entitled 'Evaluation in Health Promotion: Principles and Perspectives' (Rootman et al., 2000, cited: McQueen, 2000) pointed that in the field of health promotion, relatively few evaluations have been undertaken, at least as judged by the published literature. In particular, systemic reviews of health promotion are in short supply. However, the paucity of health promotion evaluations is less disheartening when understood in the context of difficulties in undertaking and publishing evaluations, and when compared to the state of evaluation in other fields. They have identified a number of factors that contribute to our lack of access to evaluations of health promotion.

These factors fall into **three** groups. **First**, some factors relate to our *ability to undertake* health promotion evaluations, including: (1) the inherent difficulty in undertaking evaluations of complex health promotion interventions that include the use of multi-level multi-strategy interventions, have extended time-frame, and have poor control over the implementation of health promotion initiatives; and (2) limited funding for the kinds of evaluations that are appropriate for health promotion – relatively few resources have, historically, been invested in the evaluation of the complex interventions that characterise health promotion. A **second** set of factors relate to the *criteria for assessing* the effectiveness of health promotion. There are two aspects to this challenge: (1) with respect to evaluating individual initiatives, there is a great deal of debate concerning appropriate



methodologies, variables, measures, and criteria; and (2) there is a considerable disagreement concerning appropriate criteria (e.g., randomised control trials versus community stories) for synthesising the evidence regarding the effectiveness of health promotion in general – under the influence of evidence-based medicine, there is a pressure to measure the effectiveness of health promotion against the gold standard of randomised control trials which are held to be a prerequisite criterion for inclusion in reviews of the literature. A third group of factors is characterised by the limitation of our *ability to know* about (and learn from) the evaluations that are undertaken, for a number of reasons, including: (1) there are limited outlets for publications of health promotion evaluations; and (2) it is difficult to identify the grey or fugitive evaluations that are not published in accessible journals and books.

## 2.10 Community Participation in Future Planning

One of the principles of the Ottawa Charter for Health Promotion, which were listed in chapter two, is strengthening community action to achieve better health. The charter states: “Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health”.

Whatever techniques are used to stimulate community participation, the focus to be maintained is the assessment of the situation and prioritisation of needs and problems made by citizens. Identification of problems and needs is the best starting point for community capacity building, and the goal is the participation of those who have never had the opportunity to be heard. Health administrators, leaders and politicians should listen to the problems identified by the community in order to its gain the trust and confidence (of the communities) (Restrepo, 2000).

The most important resource within any society is its people. Therefore, it is very important to involve the people in determining population needs. An important part of achieving an effective and efficient health education and promotion programme is to develop an understanding of the target audience’s view



-their perceptions, preferences and requirements. This understanding should influence the selection of message, medium and creative strategy, i.e. to ensure that the material is saying the right thing to the right people at the right time and in the right way.

In this context, the author refers to a process called 'market research'. It is a process that needs to be applied within the field of marketing; commercial or social marketing. The term '*social marketing*' was first used by Kotler and Zaltman (1971) to describe the application of the principles and methods of marketing to the achievement of socially desirable goals. Accordingly, interventions similar to health promotion and health education are frequently described now a days as social marketing.

Egger and colleagues (1999) said in this context; it should be apparent that effective marketing is a research-based process. Research in social marketing is concerned both with epidemiological data and with assessment of a number of factors such as:

- which health 'products' (for example, exercise, dietary-fat reduction, smoking cessation) does the community perceive as priorities for action?
- what tangible products can be developed to facilitate the adoption of health promoting behaviours or to reduce risk (for example, no tar cigarettes, low-fat foods, quit-smoking kits, exercise videos)?
- what programmes or services can be offered (for example, weight control, aerobics classes, educational videos on the benefits of exercise, training videos on how to institute work-site programmes)?
- how should the message strategy be developed?
- what social and structural facilitators and inhibitors need to be taken into account?
- who are the relevant influences and intermediators?



- what media (TV, radio, press) and what media vehicle (specific programmes), if any, can be used to reach the target audience(s) cost-effectively? and
- what activities are being undertaken by anti-health marketers?



**CHAPTER THREE**

**FRAMEWORK FOR  
COUNTRYWIDE PLANS OF  
ACTION FOR HEALTH  
PROMOTION**



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## **CHAPTER THREE**

### **FRAMEWORK FOR COUNTRYWIDE PLANS OF ACTION FOR HEALTH PROMOTION**

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At the Fifth Global Conference on Health Promotion, Mexico City, June 5-9, 2000, a Framework for Countrywide Plans of Action for Health Promotion (2000) was developed. The author was invited as a technical delegate to this conference and actively participated in the development of this Framework. The present research represents an area of application of this Framework. The Framework includes; Planning process, Implementation, Evaluation and Mechanisms for action.

#### **3.1 Planning Process**

##### **3.1.1 Needs assessment**

The preparation of the plans of action should follow the identification of:

- Priority health development issues to be addressed.
- Assets available (policy, legislation, human and financial resources).
- Capacity of human resources and the infrastructure available.

The national plan of action should be developed in the light of the most reliable data and experience available. The problem definition would include a review of (a) epidemiological and demographic information; (b) behavioural and social research on the determinants of health; (c) community needs and perceived priorities. The process of identifying needs and priorities must involve members of the community and relevant public and private sectors. It should include the following characteristics:

- Clearly defined objectives and expected outputs within given time frames.
- Expected outcomes clearly stated and indicators of progress identified.



- Form part of, or contribute to, the overall national development plans, and specifically of the national health plans, where such exist.
- Involvement at appropriate levels and stages of all relevant stakeholders and key contributors, including the community, NGOs, private sector, academia, religious institutions, WHO, PAHO, UN and donor agencies.

Among the tools used to identify problems, needs and issues are problem trees, the fish bone, community consultation, focus groups and surveys. In generating proposed solutions and ideas for action, it is crucial to review social and behaviour theory and intervention models, analyse evidence from other programmes, and incorporate experience of community workers and other relevant practitioners.

The ultimate objectives of health promotion plans are to improve the health of communities and individuals and to attain acceptable levels of equity in health. Incorporating strategies to bridge the equity gap in health promotion plans of action is vital.

A tool that provides positive discrimination to reduce inequities is targeting: focusing specific activities, services and resources on specific population groups or specific products such as a staple food. The criteria for targeting varies depending on the need and desired outcome: it could be increasing opportunities such as giving pre-school children a head start with early stimulation, nutrient supplements, parenting classes, etc.; transferring income to alleviate poverty; or providing water and sanitation to neighbourhoods that lack these services.

Targeting does not mean excluding groups or leaving them aside. It means providing different services to beneficiaries with different levels of needs. Targeting does have a cost, depending on the type and extent of the mechanisms and the specific criteria. Targeting low income communities, neighbourhoods and schools is sometimes less costly than targeting specific population groups.



### **3.1.2 Determining priorities, objectives and outcomes**

This step of the process often involves a list of problems to be solved, many of which implicate measures to control and prevent specific diseases. It is important to go beyond defining the problem to identify causes and consequences. It is also important to do a vision exercise and involve people in trying to visualise what they would like to see in the near and long term future.

The focus of disease prevention and health promotion is slightly different. The goal of prevention is the absence of disease, whereas health promotion seeks to create and maintain healthy and supportive environments, ensuring protective factors at the policy and community levels, providing life skills education and developing healthy life-styles and conditions. Despite these different approaches, both of them contribute to the attainment of health, and there is evidence that prevention programmes are gateways to health promotion. It is essential that the goals and outcomes decided on involve all sectors of society and are fully agreed on by the different stakeholders.

Once priorities are identified, the definition of desired objectives and outcomes takes shape. The process builds and strengthens the capacity of all involved; community members, relevant sector representatives and institutions. Once the objectives and outcomes are determined, the review of available resources and assets is needed. In order to design a plan of action, a review of training and infrastructure development issues is necessary. It is important during the entire process to raise public and political awareness. On-going consultation and communication with the broader community, as well as with policy and decision making actors in the relevant sectors, is essential for success.

### **3.1.3 Selecting the most effective strategies and interventions**

This involves selecting and adjusting the means of action most suited to the situation, the prime subjects (the target audience), the desired health objectives, the manner of the intervention (mechanisms or levels) and the setting (where).



Health promotion is principally directed at the factors that determine health and the causes of identified problems or risk conditions, rather than at their consequences. Given the diversity of the factors that determine health, cooperation between different sectors is essential, and in particular between those with economic, social and environmental responsibilities. The extent to which action in different sectors overlaps should be taken into account when planning a strategy.

The health promotion strategies that are proven to be effective have been those combining complementary actions based on different sectors of society. The most common partners in such actions are government agencies, health institutions, NGOs, schools and universities, the mass media, religious groups, and public and private organisations.

Depending on the plan of action, it will be necessary to do some development and pre-testing of methods and materials to be used. Health promotion actions often implement an education strategy. Examples include: community or popular education, school health education and teaching of life skills, patient education, including strengthening family support groups. A social communication strategy including broadcast and print media is also a feature of effective health promotion action. Social mobilisation strategies including community development, strengthening social support networks, group facilitation, targeted mass communication, and others are also used. Advocacy is an important tool, examples include lobbying, political organisation and activism, overcoming bureaucratic inertia, identifying a champion for the cause, and enabling community leader and mediation to manage conflicts.

### **3.2 Implementation**

Emphasis on implementation should be on strengthening country capacity at all levels, developing assets and resources, and getting appropriate infrastructure for promoting health. Once the needs and priorities have been identified and the objectives and outcomes agreed upon, and the action plan designed, action can be



taken. A plan is a detailed formulation of the implementation of a strategy and activities. Health can be promoted in many different ways. It can entail mediation to enable a legislator to promote a law, distribution of messages on various media, and direct provision of public and private health services. The activities in the plan must be arranged in each phase according to the schedule agreed on, to guide their timely implementation. A plan for monitoring and recording the implementation of the plan of action and for quality control must also be developed, as well as a mechanism to review the results.

The plan of action for effective health promotion involves various types of activities:

- Raising public and political awareness;
- Communicating the health promotion message;
- Proposing healthy public policy;
- Strengthening community action for health; and
- Creating supportive environments and encouraging healthy life-styles.

### 3.3 Evaluation

Ongoing monitoring and regular review should be included early on, to provide timely warning of difficulties that will require the need to refocus or redirect action plans. Outcome evaluation should be measured against agreed indicators. Unexpected results should also be carefully noted and acted on.

There are various approaches to evaluation. Some maintain that no quantifiable objectives can be set *a priori* for health promotion, and that actions cannot be determined in advance, since it is up to the individuals and communities to decide whether or not to take them. On the other hand, there is considerable pressure from sponsors, politicians and the scientific community in general. It is requesting measurable results and insisting that proposals include clear, measurable and viable objectives, and a strategic plan defining the what, who, how and when of specific activities.



To respond to these pressures, we must take up the challenge of testing and validating instruments that objectively document the process, the results and the costs of various health promotion programmes.

Evaluation is not to be equated with measurement of results, or merely gathering data on a set of indicators. Evaluation can concern the results or the process, or it can be part of training. Although health promotion must account for its results, it is equally important to understand the processes. The monitoring and evaluation of complex interventions requires different evaluation models and instruments.

Health promotion outcome measures can include:

1. Health literacy measures, which include health-related knowledge, attitudes, motivation, behavioural intentions, personal skills, and self-efficacy;
2. Social action and influence measures such as, community participation, community empowerment, social norms, and public opinion;
3. Healthy public policy and organisational practice measures, including policy statements, legislation, regulation, resource allocation, organisational practices, culture and behaviour;
4. Healthy life-styles and conditions measures, which include tobacco use, food choices and availability, physical activity, alcohol and illicit drug use and the ratio of protective versus risk factors in the social and physical environment;
5. Effective health services measures, including provision of preventive services, access to, and social and cultural appropriateness of health services;
6. Healthy environment measures, for example safe physical environments, supportive economic environments and social conditions, restricted access to tobacco, alcohol and illicit drugs, positive environments for youth and the elderly, freedom from violence and abuse;
7. Social outcomes measures include quality of life, functional independence, social support networks, positive discrimination and equity;



8. Health outcome measures encompass morbidity, disability, avoidable mortality, early stimulation and head start for education, psychosocial competencies and life skills;
9. Capacity building outcomes, including measures of sustainability, community participation and empowerment.

### **3.4 Mechanisms for Action**

Various mechanisms or strategies for action exist, each of them is different, but all of them are complementary. The five complementary mechanisms for action proposed by the Ottawa Charter are:

#### **3.4.1 Building healthy public policy**

Healthy public policy is a mechanism for investing in health, and in sustainable human and social development. Health promotion policies are the key mechanism to ensure the existence of prerequisites for health, including work, peace, education, social justice and equity.

The establishment of healthy public policies involves identifying protective factors in the physical and psychological environment that would contribute to improving the determinants of health. These may include access to work, financial security, adequate housing, universal access to quality education, food security and safety, access to healthy food, access to information, availability of safe transportation, recreation and physical activity areas, and opportunities to develop life skills and to be connected to social support networks. Healthy public policy is often translated into legislation that safeguards the necessary conditions to develop healthy life-styles. Healthy public policies protect communities, families and individuals from risk factors and conditions, and make the healthiest options the easiest choices. They also seek to achieve an equitable distribution of resources.

Policies are drawn up at various levels. At the local level, regulations serve a twofold purpose; on the one hand they provide instruments for putting into



practice concrete aspects of the major national policies; on the other hand, they are a tool for deciding certain political responsibilities that are regulated at this level, and adapting them to local needs. At the national level, legislative issues with a bearing on health are not the sole responsibility of Ministries of Health. The guidelines adopted will need to adopt the right approach in order to identify both those instrumental measures that are to be carried out at local level and those concerning the macroeconomic and social policies that determine health.

Healthy public policies are decrees, regulations and norms adopted by the state to safeguard the economic and social conditions which have a significant impact on community health.

### **3.4.2 Creating supportive environments**

By the year 2010, the majority of the world's population and their economic activities will be located in urban areas. This arouses significant concerns in terms of resource allocation, income distribution and provision of service such as water, sanitation, and pollution control. Poverty and inequities contribute to difficult psychological environments where violence is a priority issue.

In this context, health promotion proposes initiatives to empower communities and create partnerships between elected local authorities, representatives of different sectors; public and private, and community leaders to establish plans of action to create health and supportive settings. Multisectoral teams, all over the world, are joining forces to design strategies that will create supportive environments and promote health where people live, work and play. Healthy and safe environments are created by the investment of many sectors in health. The close link between psychological and social environments must also be considered.



### 3.4.3 Reorienting health services

The reorientation of health services is a process of adapting structures and function to new demands for health. The most commonly mentioned components when it comes to defining the new orientation are: preventive measures, health development strategies, intersectoral involvement, community participation, increasing equity and furthering decentralisation. It is well known that health is determined by biological factors, life-style and environmental factors. Consequently, health services must work in an alliance with other sectors that have a greater influence over the factors that determine health. The task of working with other sectors demands experience and technical skill.

For primary health care in particular, health professionals can play an important part in catering for the needs of users and helping them to participate in the provision of services. At local level, this means adapting the form and kind of services provided to the needs of population. At national level, it means assuming that health professionals are well-placed in society to create and maintain mechanisms that will contribute to the empowerment of individuals, families, populations and communities.

A full concept of equity in health must produce not only full coverage with equal opportunity of access, utilisation and quality of health services, but also the examination and correction of avoidable unjust and unnecessary factors which impair the health of various parts of the country.

Decentralisation of health services is another essential component of the transformation of the health sector. It calls for delegation of administrative and executive power from central to local levels. Its purpose is to optimise the distribution of resources and avoid duplication of skills at various levels. It also means more effective, efficient and equitable provision of health services, adapting delivery to the needs of each part of the country.



### **3.4.4 Strengthening community action**

Community action is a concept that is both exciting and complex. In fact, the term “community” can mean different things in different contexts. The traditional notion of community is a well-defined geographical area with formal institutions such as church, town hall and school, where families live whose values are rooted in a shared history. This has begun to change in places where geographical barriers have been overcome by communications and transport. People no longer live where they work and their support networks do not coincide with any geographical boundaries. These considerations must be taken into account when the activities of groups, communities or social support networks in a given area are analysed and evaluated.

Empowerment gives a sense of personal control and the ability to bring about change in the social and health conditions through collective mobilisation. Participation in the decision-making process is desirable, not only from the ethical point of view but also in order to guarantee effectiveness.

### **3.4.5 Developing individuals' skills**

Although the many factors affecting health are beyond the reach of the individual, some individual choices or life-styles -use of tobacco and alcohol, diet, exercise, and sexual practice- can influence health and well-being. Such choices can be influenced by action to empower the most vulnerable.

The distinction between individual and collective empowerment is more theoretical than real. In particular, understanding a problem and acquiring the personal ability to deal with it are the basis of collective action for social change. In a social support network, each individual keeps his or her identity while receiving material support, services, information and new social contacts.

Far from being mutually exclusive, these five mechanisms for action in health promotion are complementary. Achievement of health promotion objectives



depends on implementing an appropriate balance of strategies within these five areas.



# **CHAPTER FOUR**

## **STUDY LOCATION**



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## CHAPTER FOUR

### STUDY LOCATION

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#### 4.1 Geographical and Demographic Situation

Libya lies in the north of Africa, on the south coast of the Mediterranean sea, bordered on the east by Egypt and Sudan, on the west by Tunisia and Algeria, and on the south by Chad and Niger, (Figure 4.1). The country has a coastline of 1,900 kilometres in length and a surface area of 1,775,500 square kilometres with a population of 4.4 million in 1995 according to the National Authority for Documentation and Information (1996). Population size estimated to be 4.77 million in 1998 (NADI, 1999). In 1995, 75% of the population live in urban areas. The number of males is 103 per 100 females. The percentage of people under 15 years of age is 39.1 (NADI, 1996).



Figure 4.1: Map of Libya.



## 4.2 “Health for All & By All”: the Title and Target of Health Promotion Strategy in Libya

The Libyan Revolutionary Command Council had advocated earlier (on the First of September, 1969) the target “*Health for All*” and the participation of the state in the 30th World Health Assembly in 1977 was to affirm its contribution to the global movement “Health For All by 2000” (GSH, 1989).

Socioeconomic development in Libya was rapid between 1970-1990. Therefore, a strategy directed towards developing the human potential of citizens, with emphasis on education and health, has been implemented to meet this rapid development and a great transformation in these two sectors has been carried out (GSH, 1989). Literacy rates, estimated at only 40% for the Libyan population in 1973, have been greatly increased. In 1987 it was estimated that 81% of the population was literate, 90% for males and 70% for females (WHO, 1996), and in 1995 they are 90% for males and 74% for females (LSMCH, 1997).

The target of Public Health Strategy in Libya was considered in 1989 to be “*Health for All & By All*” (GSH, 1989). In 1995, the title of the strategy was designed as “*The National Strategy Providing Health for All and by All*” (The General Secretariat, 1995). The participation of citizens in the planning and implementation of their health care and taking control of their own health is widely seen through the popular congresses’ annual meetings, where people meet to discuss and decide about their different life issues.

A ‘High Committee’ was constituted, led by the General Secretary (Prime Minister) with the membership of the following General Secretaries (Ministers); Health and Social Welfare, Utility and Housing, Industry, Education and Scientific Research, Justice and General Security, Agriculture and Animal Wealth, and Planning & Finance. This High Committee is responsible for the follow-up of implementing ‘The National Strategy Providing Health For All And By All’ in the country (The General Secretariat, 1995).



The health promotion programme in Libya is directed at raising the health status of individuals in the community; advancing, supporting, encouraging and placing it higher in personal and public agendas.

In every society, one runs across some discrepancy in the quality of health care offered in urban and rural settings respectively (MacDonald, 1995). In Libya this discrepancy is minimised, if not eliminated, and a free health service has been established featuring universal access to public health facilities in rural and urban areas (GSH, 1989).

The goal of health policy in the country is in the direction of providing health for all and by all, to create a society in which every member can play an active role, both socially and economically. The policy gives priority to primary health care, in all its aspects, focusing on the following (13) national programmes:

Health and social education, Maternal and child health, Immunisation, School health, Prevention of diarrhoeal diseases, Prevention of acute respiratory infections, Tuberculosis prevention, AIDS control, Prevention of cardiovascular and rheumatic heart diseases, Accident prevention, Psychiatric health, Leprosy prevention, and the National programme of Eye diseases and blindness prevention.

Health education activity integrates with and represents an important element of each of the above mentioned national primary health care programmes (Tamer et al., 1990).

The Libyan Survey on Maternal and Child Health (LSMCH, 1997) highlighted a host of measurable health changes. It revealed extraordinary successes in the national vaccination programme, leading to almost universal vaccination coverage.

Life expectancy at birth among the Libyan population has risen dramatically over the past three decades. In 1960, a Libyan could at birth expect to live until the



age of 47 years (LAJ& UNICEF, 1997). By 1990, this had increased to 61 years (WHO, 1996), and to 64 years by 1995 (LAJ& UNICEF, 1997).

Over the past three decades, the country has made impressive progress in the reduction of infant and child mortality (GSHSW, 2000; NADI, 2000). In 1960, 160 per thousand infants died before reaching one year of age (UNICEF, 1997b). By 1990 this had been significantly reduced to 31 (WHO, 1996), and to 24.4 in 1995 (LSMCH, 1997). Similarly, in 1960, 269 out of every thousand Libyan children born died before the age of five (UNICEF, 1997b). By 1990, this, too, had fallen to 63 (UNICEF, 1997a), and to 30.1 in 1995 (LSMCH, 1997). Both of these 1995 figures are the lowest among the Middle East and North Africa Region (LAJ& UNICEF, 1997).

Table 4.1 shows a number of health indicators, comparing the Libyan situation in 1995 with that in 1960, and with that in some countries in the Middle East and North Africa Region (Egypt, Morocco, Saudi Arabia and Turkey), and the United Kingdom in the same year (1995), according to *The State of the World's Children Report, 1997* (UNICEF).

Health indicator	Libya (1960)	Libya	Egypt	Morocco	Saudi Arabia	Turkey	UK
		(1995)					
Infant (under one) mortality rate	160	24.4 (LSMCH,97)	40	61	29	44	6
Under five mortality rate	269	30.1 (LSMCH,97)	51	75	34	50	7
Percentage of infants with low birth weight (1990-1994)	...	4.7 (LSMCH,97)	10	9	7	8	7
Life expectancy at birth	47	64	65	65	71	68	77
Maternal mortality rate, 1991 (Unicef, 93a)	...	80	270	...	41	150	8

Table 4.1: Health indicators in Libya, Egypt, Morocco, Saudi Arabia, Turkey & UK.



These changes and improvements can be attributed to a large extent to the National Strategy of Health Promotion in the country, which gives top priority to the Health Education Programmes. However, neither health education nor improved health services could have caused these changes and improvements without the support of other sociocultural and structural factors.

The Office for National Statistics quoted in the Population Trends, 1997 edition, in this context: "Many factors are likely to have influenced trends in health in the UK over the past years, including changes in standard of living, food availability and nutrition, physical environment, hygiene, life-styles, the social environment, and the role of health services and medical science".

#### **4.3 Health Education Programmes in Libya: A Challenge to Meet Aspirations**

The eight essential elements of primary health care, as stated in Alma-Ata, were affirmed by the health policy in Libya (GSH, 1989). They were extended by the National Strategy Providing Health For All & By All in the country in 1995 to include social education, psychiatric health, occupational health, and social and health care of elderly people, giving higher priority to health and social education (The General Secretariat, 1995).

Health education programmes in Libya are planned to present opportunities for people to think about health and to undertake voluntary changes in their health-related behaviour. They include providing information, exploring values and attitudes, making health decisions and acquiring skills to enable behaviour change to take place and they involve promoting self esteem and self empowerment, so that people are enabled to take action about their health (Abdelhadi et al., 1997). There is a particular emphasis on educating children and young people, as they face decisions about such diverse problems as personal hygiene, diet, accidents and smoking at a very early age and accordingly they need to be empowered to make wise health choices before reaching adulthood (Elfituri et al., 1997).



The Libyan health education programme relates to all aspects of health behaviour, including the use of health services. It is designed to help people improve their personal habits and to make the best use of the community health services. It is an integral part of the health service and all health personnel accept responsibility for contributing to the programme (GSHSW, 1994; 1995 and 1996).

The health education service has been developed and improved over the past twenty or so years. Today, the General Secretariat of Health and Social Welfare plays the key role in health education programmes through the National Committee for Health & Social Education, which has been recently formulated (1995). The author is the head of this national committee since 1995, which represents a team drawn from the leaders of health education, promotion and public health in the country.

This committee is responsible for the planning and implementation of national programmes of health and social education. It also supervises and directs national health education activities, organised by the General Directorate of Health and Social Education, of which the author served as General Director in the period of 1992 to 1994. It also co-operates with the General Directorate of Primary Health Care, as well as other technical and scientific committees and national programmes at the General Secretariat of Health & Social Welfare in their projects.

The plan of action of health education in Libya was included in the general plan of action of The General Secretariat of Health and Social Welfare. However, recently (1997) the author's colleagues; A. Abdelhadi, H. Tamer and A. Ali, and himself, developed a separate plan of action: namely, The National Plan of Health Education. It includes:

- the main targets of the plan;
- methods of implementing the targets and maximising co-operation;
- job descriptions of central and local authorities;
- financial support assessments;



- designation of channels of health education;
- annual programmes and projects.

The National Committee for Health and Social Education organises programmes, projects, training and research and supports health and related boards and local authorities with their own health education activities.

It provides information and advice about health, directly to members of the public, and it supports other organisations and people who provide health education to members of the public. This is accomplished by using the most appropriate, acceptable and effective ways to achieve the aims and objectives.

Health education is not merely the responsibility of the General Secretariat of Health and Social Welfare and its institutions. It is a shared responsibility with the other General Secretariats, such as The General Secretariat of Education, Information, Youth & Sports, Transport, Housing, Economics, Planning and Commerce, Industry, Energy, and Justice with their establishments and local authorities. It also involves some popular (governmental) organisations, such as the Environment Protection Organisation, National Media (TV, Radio and Newspapers) and some voluntary groups including Youth Organisations and the General Movement of Scouts. Professionals' unions and societies, such as the Physicians' Union and the Pharmacists' Society, and many other agencies, are also involved. Moreover, WHO as well as UNICEF are technically co-operate and support the national programmes of health education (Abdelhadi et al., 1997).

A variety of methods, both formal and informal, are used. Some are *personal*, i.e. involving a health worker in direct contact with an individual or a group. Others are *corporate*, in which the communication does not involve such contact e.g. the use of posters, leaflets, and the mass media (newspapers, radio and TV). In particular, it concentrates on the mass media, as these are effective popular forms of communication that are used increasingly to inform the public and to draw attention to health issues, at any given time, which then become a matter of public interest and debate (Elfituri, 1996c).



Both of the two national TV channels, as well as the seven national and local radio stations, present different health spots many times a day, seven days a week, between other programmes during the hours of broadcasting. Each of the national TV channels presents three health education programmes a week; one of half an hour and two of 15-20 minutes. The author used to prepare and present one of them (1990-1995), namely: "*Health for All*". Each of the radio stations presents between two and four health education programmes a week, of half- to one hour each, in addition to the health spots around the clock. These programmes and spots broadcast different messages about protecting and promoting health (Elfituri, 1996b).

In a booklet called "*Health Facts for All*", which has recently been published (1997), the author's colleagues and himself conveyed the essential health information that people have the right to know, in plain language. "Health Facts for All" is intended for those who can help to communicate its essential health promotion message to all sorts of people. It is a way of inviting a wide range of individuals and organisations to become involved in protecting and promoting community health by using their communication resources and skills.

The following are the principle messages distilled from "Health Facts for All":

(1) The health of both women and children can be significantly improved by spacing births at least two years apart, and by avoiding pregnancies before the age of 18 and after the age of 35.

(2) To reduce the dangers of childbearing, all pregnant women should go to a health worker for prenatal care and all births should be assisted by a trained person (in Libya, at least a midwife).



(3) For the first few months of a baby's life, breast-milk alone is the best possible food and drink. Infants need other foods, in addition to breast-milk, when they are about six months old.

(4) Children under the age of three have special feeding needs. They need to eat five or six times a day and their food should be specially enriched by adding mashed vegetables and small amounts of fats or oils.

(5) Diarrhoea can kill by dehydration. The liquid lost each time the child passes a watery stool must be replaced by giving the child plenty of the right liquids to drink; breast-milk, diluted gruel, soup or Oral Rehydration Therapy (ORT). If the illness is more serious than usual, the child needs help from a health worker and the ORT. A child with diarrhoea also needs food to make a good recovery.

(6) Immunisation protects against several diseases which can cause poor growth, disability and death. All immunisations should be completed in the first year of child's life. Every woman of child-bearing age should be immunised against tetanus.

(7) Most coughs and colds will get better on their own, but if a child with a cough is breathing much more rapidly than normal, then the child may be seriously ill and it is essential to go to a health centre quickly. A child with a cough or cold should be helped to eat and drink plenty of liquids.

(8) AIDS is a fatal and incurable disease which is passed on mainly by sexual activity. Intercourse is safe if both partners are free of infection and if they only have sex with one another.

(9) Illness can be prevented by washing hands with soap and water after contact with faeces and before handling of food, using clean water and keeping food clean (Elfituri et al., 1997).



“Health Facts for All” also covers the following subjects;

Personal hygiene, Healthy food, Accident prevention, Anti-smoking, Anti-alcohol, Anti-drugs, Oral health, Safe use of pharmaceuticals, Safe diabetes and hypertension. Different educational materials, such as leaflets, booklets and posters about the above mentioned aspects are frequently produced and distributed.

Long and short term health campaigns organised with the co-operation of the related authorities and agencies, such as the Annual Arab Magrabian Campaign against diarrhoeal diseases (mid May to mid September), the Annual Arab Maghrabian Immunisation Week (10-17th October), AIDS Control Month (December), Healthy Heart Campaign, No Tobacco Days, and the Continuous Campaign Supporting Breast-feeding (Elfituri, 1996b).

The author also served as the General Supervisor of a quarterly general public health education magazine, namely: *Al-Manara*, which was first published in 1992, by the General Secretariat of Health and Social Welfare, and distributed all over the country.

These programmes were very successful at penetrating the market and raising awareness (Elfituri, 1993), especially in maximising parental co-operation in bringing children forward for vaccination, in improving mothers' knowledge of using oral rehydration fluids and protecting their children from dehydration, in protecting the community from AIDS, and defending non-smokers from positive smokers.

In order to ensure that health education programmes are functioning properly, a process of evaluation has to be built in (Hawe et al., 1991; Doyle & Thomas, 1996). Nevertheless, very little research has been done on the organisation and management of health education services and their elaboration in the developing countries (Dehne & Hubley, 1993) and no single study to evaluate the National Health Education Programmes in Libya and to determine future needs has been carried out.



# **CHAPTER FIVE**

## **RESEARCH DESIGN**



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## **CHAPTER FIVE**

### **RESEARCH DESIGN**

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Research design is the overall strategy for deciding what information is to be collected, from whom, and the methods employed.

#### **5.1 Research Principles**

The present research is conducted on the basis of four principles. These are:

- 1- Any field of action in public health rises above rhetoric only if it can ultimately demonstrate that it can make a difference to public health. Evaluation is the heart of this demonstration (McQueen, 2000).
- 2- Evaluation is of considerable importance to inform the design of future initiatives. An integral part of programme planning must be a review of previous similar initiatives, in order that the lessons learnt through their evaluation can be incorporated into the design of the new programme (Downie et al., 1997).
- 3- “Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health” (Ottawa Charter for Health Promotion, 1986).
- 4- It is considered that health professionals are well placed in the society to create and maintain mechanisms that contribute to the empowerment of individuals, families, populations and communities (Framework for Countrywide Plans of Action for Health Promotion, 2000). Health professionals are considered to be an important medium for health education and health promotion (WHO, 1984).



## **5.2 Research Aims**

The research attempts to reach the following aims:

- 1- To document and evaluate the existing national programmes of health education.
- 2- To develop an understanding of the officials' and general public's views: perceptions, needs, preferences and recommendations for future health education planning in Libya.
- 3- To suggest modifications and amelioration in order to enhance the existing programmes.

## **5.3 Research Objectives**

The objectives of the present research are:

- 1- To document health officials' assessment of the effect of existing national programmes of health education, and their role in promoting the health of the Libyan community.
- 2- To analyse and determine the overall effectiveness and efficiency of the employed health communication media, both as sources of health knowledge and as influencing factors for healthy behaviours.
- 3- To identify the most successful health education interventions within the health promotion programmes.
- 4- To demonstrate that two events have occurred: firstly, that significant changes in knowledge and health practice have taken place; and secondly, that these changes have taken place as a result of the health education programmes.



- 5- To determine the priority health issues and groups of people, which and to whom future health education programmes should be addressed and directed.
- 6- To select the medium/media most appropriate for each health issue and for each group of people.
- 7- To compare the officials' assessment with that of the general public, in order to identify techniques and areas of action for future planning.
- 8- To assess the perception of health professionals on health education practice.
- 9- To study the barriers and suggest actions for a more effective role for health professionals in health education.
- 10- To document the health officials' and the general public's suggestions and recommendations for future health education programmes.

#### **5.4 Research Hypotheses**

Research hypotheses are:

- 1- Health officials and the general public both judge national health education programmes to be successful, effective, and efficient in promoting community health in Libya.
- 2- Health education programmes are very successful in maximising parental co-operation in bringing their children forward for vaccination; in improving mothers' knowledge of the use of oral rehydration fluids and protecting their children from death as a result of diarrhoea; and in protecting Libyan youth from AIDS.



- 3- TV is the most potent health communication medium for health promotion messages, and the most influential factor for healthy behaviours. It is also the preferred medium for conveying most health messages related to future planning.
- 4- Health professionals and school education are, presently, much less important sources of health knowledge, and of minor effectiveness as influencing factors.
- 5- Targeting school children by future health education programmes is accorded as a priority.
- 6- Prevention from modern diseases such as Cardiovascular Diseases and Cancer, Control of AIDS and Drug Abuse, and Promotion of Physical Exercise are the priority areas recommended by the general public to be addressed by future health education programmes in the Libyan community.
- 7- Health issues and groups of people which the general public recommend to be covered or targeted by future health education programmes are different from those recommended by health education/promotion officials.
- 8- Health professionals are willing to contribute actively in public health education. However, lack of information on health education, disease-orientation and poor communication skills are the main barriers to a more effective role.
- 9- Perceptions of health professionals working in the preventive medicine field on their role in health education are more optimistic than are those of professionals working in the curative medicine field.
- 10- It is highly recommended to grant more support and pay more attention to improve the health education component within school and health services settings.



- 11- Organisations outside of the health sector are widely perceived to be relevant and their involvement is seen as crucial.

### **5.5 Research Structure**

This research in health education programmes in Libya is composed of three parts. They are:

Part One: Evaluation of the existing situation.

Part two: Assessment of future needs.

Part three: Role of health professionals in health education: Perceptions and actions for improving the service.

### **5.6 Research Instruments**

This research utilised a combined approach of qualitative and quantitative techniques. Three different forms of questionnaires were posed, for data collection, within this research. In the first and second parts of this research, questionnaires were addressed to health officials and the general public (providers and users). The third part addressed the health professionals. Details of study population and issues addressed will be explained within the following chapters.

Stratified random sampling was the method of sampling within the general public group. This was to increase the precision of the sample and to guard against obtaining, by chance, an unrepresentative sample which under –or over- represent the population (Bowling, 1997).

In the third part of this research, the Likert scaling method was used to measure health professionals' attitudes towards the addressed issues. This method is relatively quick and believed to be the most popular scaling method for attitude measurement (Edelmann, 1996).



Used questionnaires were self-administered. This method was employed in order to ensure a high response rate, accurate sampling and a minimum of interviewer bias, while permitting interviewer assessments, providing necessary explanations and giving the benefit of a degree of personal contact (Bell, 1997 & Oppenheim, 1997).

Since open questions design is essential where answers are too numerous to pre-code (Bowling, 1997), the second part of the present study; assessment of future needs, employed an open-end questionnaire technique. This technique, also, avoids bias of presented response choices (Oppenheim, 1997). Nevertheless, open questions are difficult to answer, time consuming and may lead to a lower response rate, when compared with questionnaires consisting of closed questions (Bowling, 1997 & Oppenheim, 1997).

A covering introductory letter was enclosed with each copy of the questionnaires used. The letter was typed on headed note-paper of the National Committee for health and Social Education. This was considered efficacious in increasing response rate (Oppenheim, 1997), especially if it is issued from a legitimate body (Campanelli, 1995).

## **5.7 Ethical Considerations**

The aims and objectives of this research, together with the research design and methodology, were revised and approved by the National Committee for Health and Social Education. Members of the Committee reviewed the questionnaires and gave some recommendations for the research plan.

Participants' informed consent to take part in the research was obtained. Questionnaires were answered anonymously and confidentiality was assured.



## **5.8 Questionnaires Piloting**

In order to test how long it takes recipients to complete the questionnaires, to check that all questions and instructions are clear and to enable the researcher removing any items which do not yield usable data (Bell, 1997), all questionnaires were primarily piloted to samples representative of the study populations.

## **5.9 Data Analysis**

The resulting data were entered on the computer using EPI-info and analysed using SPSS-PC for descriptive statistics. Discussion and analysis took place in the light of collected information about national health promotion programmes; demographic and epidemiological data; and life-style practices. Results were compared with available literature on similar health promotion interventions around the globe.

## **5.10 Operational Definitions of Terms**

Health officials refer to those key people in the public health services. They include planners, policy makers, administrators, advisors of primary health care, public health and health education programmes, at both central and local levels. Health professionals include medical and public health workers with different qualifications, from different backgrounds, specialities, and fields of work.

## **5.11 Study Limitations**

1- Questionnaires of the research used ordinary A4 sheets. This might be considered to negatively –or at least not positively- affect response rate. This was due to lack of financial support from the National Committee for Health and Social Education and the General Secretariat of Health and Social Welfare, since no budget is allocated for evaluation or research proposals in the field of health education.



- 2- Lack of research in the related field in Libya led to immense difficulty in gathering information at national level and in carrying out analysis and discussion of the obtained results within the Libyan context.
- 3- Language represented another limitation in this research. Since the research took place in Libya, questionnaires had to be formulated in English, then translated to Arabic for distribution. Answers had to be translated back to English. A significant proportion of reviewed literature about the Libyan and middle-eastern communities is in Arabic and had to be translated into English as well.
- 4- Answering the open-end questionnaire, utilised in the second part of the research, was time consuming and may have led to a low response rate. This is more applicable to the general public group, in which participants may have lacked interest and did not expect to receive a feed back of study findings.



**CHAPTER SIX**  
**(PART ONE)**  
**EVALUATION OF THE EXISTING**  
**SITUATION**



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## ***CHAPTER SIX (PART ONE)***

### ***EVALUATION OF THE EXISTING SITUATION***

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#### **6.1 METHOD**

In this evaluative research, two forms of a closed-end questionnaire were used.

##### **6.1.1 First Questionnaire (Officials Group)**

###### **6.1.1.1 Study population**

The study population included the members of the National Committee for Health and Social Education, the National Managers of primary health care and health promotion programmes, the Directors of primary health care departments and health education departments in the 13 local districts of the state, as well as, the members of national committees and programmes of health promotion who are university staff members.

###### **6.1.1.2 Research questions and data analysis**

The questionnaire was designed to ask the officials, how they would evaluate the present national programmes of health education, in which five optional answers were presented; 'Excellent', 'Very good', 'Good', 'Average', and 'Poor'. The participants were asked whether or not they see health education programmes play a role in the protection and promotion of health of the Libyan community. They were requested to inform about their estimation of the impact of these programmes on the Libyan community, by choosing the perceived right answer among five given answers; 'Highly effective', 'Effective to certain extent', 'Effective', 'Not effective', and 'Not sure'. Frequency for selecting each answer to these questions was obtained and discussion was carried out accordingly. Whether



health education programmes in the country are effective for specific groups was another inquiry within this questionnaire, and to which groups, if any.

This questionnaire asked the participants to place in a rank order the perceived positive role of health education interventions within the main health promotion programmes. Participants were also requested to rank in order the employed health education media according to their estimated efficiency in the promotion of the health of the Libyan community. Rank order of each participant was translated into scores. 100 scores for the ranked first, 90 for the second and so on, down to 10 scores for the ranked tenth. Total score then is obtained. Analysis and discussion took place accordingly. A space for comments, suggestions and recommendations for improving the existing situation was available (see Appendix A, page 376).

#### **6.1.1.3 Variables**

Variables of this questionnaire included qualification and current occupation.

#### **6.1.1.4 Piloting and procedure**

During the summer of 1997, 50 copies of the first form of the questionnaire were handed, personally, to the health education and promotion officials, after piloting ten copies to a representative sample.

### **6.1.2 Second Questionnaire (General Public Group)**

#### **6.1.2.1 Study population**

The study population included samples representative of the general public configuration (both sexes, with different ages and levels of study, in both urban and rural areas).



### **6.1.2.2 Research questions and data analysis**

The questionnaire covers enquiries about health knowledge and healthy behaviours. Ten particular health issues were presented and the participants were asked to tick each issue for which they were aware of having received any information. Ten related practical applications for the mentioned health issues were presented as well, so that the participants could tick the ones they practice. Frequency for each was then obtained.

The participants were asked whether or not they see the existing health education programmes as having an effect in promoting the health of the Libyan community. The perception of effectiveness of different communication media in raising health knowledge was assessed by presenting the designated media and requesting the participants to rank them in order, according to their perception. Rank order of each participant was translated into scores as explained earlier. 13 different sources and influencing factors were presented and the participants were asked to tick in front the ones that led them to adopt any of the healthy behaviours. (see Appendix B, page 378).

### **6.1.2.3 Variables**

Variables of the second form of questionnaire included; gender, age, level of study and area.

### **6.1.2.4 Piloting and procedure**

During 1997, 150 copies of this questionnaire were piloted to a representative sample of the targeted participants. Corrections and modifications were made accordingly. 1500 copies were then handed, with the aid of colleagues and friends to the targeted population.



6.2 RESULTS

6.2.1 First Questionnaire (Officials Group)

6.2.1.1 Response rate

Out of the handed out 50 copies, 46 copies of the completed questionnaire were collected (response rate is 92%), as per Table 6.1.

No. of targeted officials	No. of respondents	Percentage
50	46	92.0

Table 6.1: Response rate.

6.2.1.2 Description of participants

Tables 6.2 and 6.3 illustrate the description of the officials participated in this study according to their occupation and leading qualification respectively.

Occupation	No. of participants
Member of the National Committee for Health and Social Education	6
National Manager of primary health care/health promotion programmes	7
Director of primary health care/health education departments in the local districts	26
Member of national committees/programmes of primary health care and health promotion who are university staff members	7
Total	46

Table 6.2: Official participants according to their occupation.



Qualification	No. of participants
Intermediate diploma in public health	10
BSc in medicine, pharmacy or health	16
MSc in health or medical sciences	4
PhD in health or medical sciences	16
<b>Total</b>	<b>46</b>

Table 6.3: Official participants according to their qualification.

**6.2.1.3 General assessment of the existing National Programmes of Health Education**

Twenty-six out of 46 of the questioned health education and promotion policy makers and managers (56.5%) assessed the existing health education programmes as ‘good’ or better. Seventeen of them (37%) estimated these programmes as ‘good’, 7 (15.2%) gave them a ‘very good’ grade, and 2 (4.3%) evaluated them as ‘excellent’. Another 17 out of the 46 participants (37%) estimated the existing programmes as ‘average’, and 3 (6.5%) as ‘poor’. Table 6.4 shows the officials’ assessment.

Grade	Number	Percentage
Excellent	2	4.3
Very good	7	15.2
Good	17	37
Average	17	37
Poor	3	6.5
<b>Total</b>	<b>46</b>	<b>100</b>

Table 6.4: The officials’ general assessment of the existing National Programmes of Health Education.



**6.2.1.4 Role of health education programmes in the promotion of health of the Libyan community**

Forty-five out of 46 of the participants estimated the health education programmes to play a role in the protection and promotion of the health of the Libyan community.

**6.2.1.5 Effectiveness**

Table 6.5 shows that 26 participants (56.5%) assessed these programmes to be ‘effective’ or ‘highly effective’, 17 (37%) to be merely ‘effective to certain extent’, and 3 (6.5%) are not sure.

Effectiveness	Number	Percentage
Highly effective	7	15.2
Effective	19	41.3
Effective to certain extent	17	37
Not effective	0	0
Not sure	3	6.5
Total	46	100

Table 6.5: Effectiveness of National Programmes of Health Education as perceived by the health officials.

**6.2.1.6 Effectiveness for specific groups**

Table6.6 shows the perceived effectiveness of National Programmes of Health Education for specific groups.



Effectiveness for specific groups	Number	Percentage
Effective	32	70
Not effective	14	30
Total	46	100

Table 6.6: The perceived effectiveness of National Programmes of Health Education for specific groups.

Specific groups influenced are shown in Table 6.7.

Specific groups affected	Number	Percentage
Educated people	20	43.5
Targeted people	12	26.1
People in urban areas	3	6.5
Mothers	7	15.2
Children and school students	3	6.5
Elderly people	1	2.2
General public	1	2.2
Patients with chronic diseases	1	2.2

Table 6.7: Specific groups influenced.

#### 6.2.1.7 Positive role of health education within the existing national health promotion programmes

Total scores for the positive role of health education within the existing health promotion programmes are illustrated in Table 6.8.

#### 6.2.1.8 Efficiency of the existing health education media in the promotion of health within the Libyan community

Rank order of the existing health education media according to their efficiency in the promotion of health within the Libyan community is shown in Table 6.9. The table presents the total scores given to each of the media.



Programme	Total scores %
Immunisation	96.3
Breast-feeding	78.9
Control of Diarrhoeal diseases	75.0
AIDS prevention	60.2
Smoking prevention	51.5
Proper use of pharmaceuticals	45.6
Accidents prevention	41.3
Oral health	38.0
Physical exercise	34.7
Prevention of cardiovascular diseases	28.9

Table 6.8: Total scores for the positive role of health education within the existing health promotion programmes.

Medium	Total scores %
TV programmes	86.0
TV spots	82.6
Radio programmes	60.6
Radio spots	51.3
Posters	48.4
Lectures, symposia and mosque	47.6
Health professionals	43.6
Books, magazines and newspapers	40.4
Booklets and leaflets	40.0
School health education	38.2

Table 6.9: Total scores given to the existing health education media according to their efficiency in the promotion of health within the Libyan community.

6.2.1.9 Suggestions and recommendations

Table 6.10 demonstrates the suggestions and recommendations given by the participants, along with the number of participants gave each suggestion or recommendation.



<b>Suggestion/recommendation</b>	<b>Number</b>
More moral and financial support	14
Training health professionals and related people, and/or preparation of health education specialists	8
Using popular gathering places (e.g. sport & youth clubs, beaches, and workplaces)	5
Continuity	3
More and more intensive health education programmes	3
Increase number and length of TV programmes	3
Improve TV spots	2
Focus on drama	1
More emphasis on TV instead of written materials	1
Same emphasis on media other than TV	1
Pay more attention to school and nursery health education	11
Draw attention to mosque's health education role	1
Concentration on evaluation	1
People determine their own health education needs	1
Intersectoral and public organisations co-operation	2
Co-operation of sociologists and psychologists	2
Direct programmes to target groups	1
Participation of scientific institutions	2
Support local health education departments with educational audio-visual materials	1
Using hospitals and primary health care waiting rooms	3
Mobile health education programmes in rural areas	2

Table 6.10: Suggestions and recommendations given by the participants.



6.2.2 Second Questionnaire (General Public Group)

6.2.2.1 Response rate

Out of the distributed 1500 questionnaires, 872 replies were received (response rate is 58.13%), as per Table 6.11.

No. of targeted people	No. of respondents	Response rate
1500	872	58.13%

Table 6.11 : Response rate.

6.2.2.2 Description of participants

Table 6.12 distributes the public participants according to their area, gender, level of study and age.

Variable		Number (n= 872)	Percentage
Area	Urban	648	78.00
	Rural	188	22.00
Gender	Male	410	47.00
	Female	468	53.00
Level Of Study	Illiterate	23	2.64
	Read & write	23	2.64
	Preparatory school	40	4.59
	Primary school	112	12.84
	Secondary school	361	41.40
	University	313	35.89
Age	20 years or less	124	14.00
	21-30 years	435	50.00
	31-40 years	207	24.00
	41 years or above	106	12.00

Table 6.12: Description of public participants.



6.2.2.3 Received knowledge on health issues

The number of participants with some knowledge on each selected health issue is shown in Table 6.13.

Health issue	Total number (n= 872)	Percentage
Importance of hygiene for the prevention of diseases	769	88
Tooth care and oral health	703	81
Prevention of cardiovascular diseases	477	55
Role of physical exercise in health protection	712	82
Adverse effects of miss-use of pharmaceuticals	622	71
Harmful effects of smoking	725	83
Significance of vaccination	612	70
Following of safety rules for prevention of accidents	596	68
Regular medical check-up role in the prevention of diseases	584	67
Importance of Oral Rehydration Therapy use to protect children with diarrhoea from dehydration	490	56

Table 6.13:Distribution of participants according to their knowledge on selected health issues.

6.2.2.4 Practice of healthy behaviours

The number of participants practising each of selected healthy behaviours is given in Table 6.14.

6.2.2.5 Efficiency of the existing health education programmes on the promotion of health

Eight hundred and fifty-three of the participants (97.8%) ticked ‘Yes’ in front of this question.



Healthy behaviour	Total number (n= 872)	Percentage
Taking care of personal hygiene	832	95
Regular use of tooth paste and brush	731	84
Eating healthy food	587	67
Practising physical exercise	410	47
Proper use of pharmaceuticals	638	73
No smoking	735	84
Follow-up of vaccination programme	543	62
Regular medical check-up	366	42
Following roads safety rules	618	71
Using ORT in case of child diarrhoea within the family	518	59

Table 6.14: Distribution of participants according to their practice of selected healthy behaviours.

6.2.2.6 Effectiveness of employed health education media in raising health knowledge

The rankings given by the participants of the effectiveness of different health education media in raising knowledge about health issues are shown in Table 6.15.

Medium	Total Scores %
TV spots	73.5
TV programmes	70.0
Books, magazines and newspapers	50.9
School health education	50.4
Radio programmes	48.6
Radio spots	47.1
Health professionals	43.1
Posters	36.1
Lectures, symposia and mosque	36.0
Booklets and leaflets	30.6

Table 6.15: Effectiveness of different health education media in raising health knowledge.



6.2.2.7 Source of influence to undertake healthy behaviours

The number of participants affected by each source of influence to undertake healthy behaviours and their percentage over the total number of participants are given in Table 6.16.

Source of influence	Participants selecting each source	
	Number (n=872)	Percentage
Family	706	81
TV	581	67
Reading books	510	58
School curricula	473	54
Magazines	452	52
Radio	344	39
Friends	323	37
Newspapers	318	36
Health professionals	306	35
Posters	256	29
Lectures/symposia/mosque	252	29
Peers/colleagues	210	24
Booklets/leaflets	180	21

Table 6.16: Efficiency of different health education media to practice healthy behaviours.

6.2.2.8 Comparison between percentage of participants who have some health knowledge with that of who practice healthy behaviour

The percentage of participants with some knowledge on selected health issues is compared with that of who practice the related behaviours is shown in Table 6.17.



Health issue	Knowledge %	Behaviour %
Personal hygiene	88	95
Oral health/Tooth paste and brush	81	84
Prevention of cardiovascular diseases/Healthy diet	55	67
Physical exercise	82	47
Proper use of pharmaceuticals	71	73
No smoking	83	84
Vaccination programme	70	62
Regular medical check-up	67	42
Accidents prevention/roads safety rules	68	71
ORT use in case of child diarrhoea	56	59

Table 6.17: Comparison between health knowledge & practice of healthy behaviours.

6.3 DISCUSSION

The present study is the first to evaluate the existing Libyan programmes of health education. It followed the recommendations of the Ottawa Charter for Health Promotion and the Mexico Framework for Countrywide Plans of Action for Health Promotion. Evaluation is an important process within the plans of action for health promotion, and community participation is essential for conducting this process. The study included participants of two groups; providers and users. It secured the participation of health officials from different fields and at both central and local levels. The general public participants were secured to be a sample representative of the Libyan population configuration.

6.3.1 General Assessment of the Existing National programmes of Health Education

Over half of the questioned health officials (56.5%) assessed the existing national health education programmes as ‘good’ or better. Seventeen (37%) assessed the existing programmes as ‘average’, and only 3 (6.5%) as ‘poor’. 98% perceived these programmes to play a role in the protection and promotion of health of the Libyan community, of which, 56.5% assessed them as ‘effective’ or ‘very effective’. A similar result (98%) was obtained from the public participants in



assessing the health education programmes to have a positive influence in the promotion of health.

These results reflect the general consideration of health officials, as well as the general public, due to the apparent general promotion of the health of the Libyan population (NADI, 2000a). This is clearly shown by national, and international reports, surveys and statistics, as well as the wide variety of health education techniques and programmes organised. These results also confirm the previous findings of the Health and Social Education Directorate reports (1993; 94; 95) and of the author's report (1996). These reports demonstrated progress and increased effectiveness of the existing health education programmes, and the important role these programmes play in raising the level of knowledge, and subsequently changing attitudes and behaviours, therefore improving the health situation of the Libyan community.

Three previous surveys of health promotion interventions concluded that the majority of health promotion interventions are effective (Gatherer et al., 1979; Bell et al., 1985; Green & Lewis, 1986). Gatherer and colleagues (1979) found that 85% of 62 studies reported improved knowledge levels, 65% of 39 studies reported changed attitudes in the desired direction, and 75% of 123 studies reported behavioural change.

This confirms the author's hypothesis that the national health education programmes are estimated to be successful, effective, and efficient.

### **6.3.2 Effectiveness of Health Education Programmes and General Public Health Knowledge and Practice**

The national programme of immunisation is estimated by the health officials to lead the health promotion programmes in the country by attributing its success to the positive role of health education programmes.



This result is supported by other investigations who revealed an extraordinary success in the expanded national programme of immunisation, and indicated that vaccination coverage rates are almost universal in Libya (LAJ & UNICEF, 1997; LSMCH, 1997; GSHSW, 2000a; NADI, 2000a).

Table 6.18 shows the percentage of fully immunised one year old children (1992-95) in Libya compared with some North African and Middle Eastern countries, as well as the UK, according to *The State of the World's Children, 1997* (UNICEF).

	Libya	Egypt	Morocco	Saudi Arabia	Turkey	UK
TB	99	95	93	93	42	..
DPT	96	90	90	97	51	92
Polio	96 100 (DIC, 97)	91	90	97	51	94
Measles	92	90	88	94	42	92

Table 6.18: Percentage of fully immunised one year-old children in Libya, Egypt, Morocco, Saudi Arabia, Turkey and UK.

This finding is in agreement with the confirmed role of health education in the success of the national programmes of immunisation in the Arab Maghribian states (UNICEF, 1993c).

It confirms the Libyan health officials' conviction that the relatively universal vaccination coverage in the country is largely attributable to the active and extremely important role that health education programmes. These programmes played a significant role in the social mobilisation effort; disseminating immunisation messages, publicising campaign launches, and broadcasting skits portraying the dangers of the child-killing diseases.

The extraordinary success of the expanded national immunisation programme is also attributed to the Compulsory Immunisation Statute issued in 1970, which obliges every child in the state to be vaccinated, and is modified according to the WHO recommendations.



However, only 70% of public participants indicated that they received some information on the importance of vaccination programme. Follow-up of the programme is mentioned only by 62%. This could be because the sample includes more than parents.

Promotion of breast-feeding was regarded by the participants to be the second programme which can attribute its success to the health education programmes.

This view meets the author's early expectation (Elfituri, 1996b) regarding the role of the existing extensive and highly effective health education programmes in forming an adequately supportive system and encouraging environment for successful breast-feeding. These findings are obviously confirmed by the elaboration which has occurred in the promotion of breast-feeding in the country over the past years. It can also be attributed to the implementation of the Baby Friendly Hospital Initiative in the country, including the discontinuation of free distribution of breast-milk substitutes.

Previous investigators (Bordom, 1991), strongly recommended increased education for mothers on breast-feeding and proper lactation management, as traditional misconceptions among Libyan mothers were prevalent. In accordance with this, increasing attention was being paid to educate mothers and other caregivers on children's nutritional needs (LAJ& UNICEF, 1997).

The mean duration of breast-feeding has been improved from 8.8 months in 1988 (Bredan, 1988), to 11 months in 1995 (LSMCH, 1997). Compared with 8.3 months in Egypt, 4.2 months in Saudi Arabia, and 7.1 months in Sudan (WHO, 1995). The results of the Libyan Survey on Maternal and Child Health (1997) also indicate that 91% of children were breast-fed.

The author recorded the quantities of baby formula imported to Libya over the period 1991-1995. These quantities have been reduced within this period, due



to the reduction of baby formula usage, and this clearly confirms the successful promotion of breast-feeding in the country (Elfituri, 1998).

The questioned health officials assessed diarrhoea control to be the third programme influenced positively by the impact of health education activities among the presented programmes.

This assessment confirms the previous findings regarding Libyan mothers' increased awareness of oral rehydration therapy (ORT) to prevent dehydration, at 93% (LSMCH, 1997), and home fluids at 75% (Bara et al., 1994, cited: LAJ& UNICEF, 1997). However, Sudanese mothers, for instance, are almost ignorant of the need for rehydration (UNICEF, 1993).

This finding is supported by the improved use of ORT, at a rate of 78% of all diarrhoeal cases (LSMCH, 1997). However, ORT is only given to 43%, 29%, 58%, and 16% of all diarrhoeal cases in Egypt, Morocco, Saudi Arabia and Turkey respectively (UNICEF, 1997b). It is also supported by the results of a previous survey carried out in 1989 which showed that after just one year of a health education campaign, ORT use in Jordan had increased from 31 to 67% (UNICEF, 1992).

As well, this evaluation of the evidence is reflected in the general improvement of the health situation in the community, especially the raised hygiene awareness and increased rate of breast-feeding, and the positive role health education interventions play within them.

However, in this study only 56% of public participants mentioned that they are aware of ORT, and 59% indicated that they now use it. This could be because our public questionnaire targeted more than mothers.

The national programme of AIDS control is ranked by the participants as fourth among the national programmes of health promotion, in connecting its progress with health education activities.



This conclusion harmonises with the dramatic success of the national programme of AIDS control. The programme is centred on public education, with the association and co-operation of the national programme of health education. This places Libya as one of the leading countries in the world with respect to AIDS prevention. Reported cumulative AIDS cases in Libya until 1995 are 17 (WHO, 1997), until 1996 are 21 (National Programme for AIDS Control, 1997), and until 1997 are 27, compared with 168 in Egypt, 464 in Morocco, and 349 cases in Saudi Arabia until 1997 as well (WHO, 1999b).

The conservative Libyan society, legislating against sexual activity between unmarried couples, and the high precautions taken in the medical services together with health education programmes have probably played a major role in AIDS prevention in this country.

However, it must be observed that extrinsic moral constraints of this type are often notoriously associated with a high, but hidden, incidence of defection from it. With potentially fatal disease conditions this can never be a good thing. The fact that statistics related to the Libyan context, do not suggest that large scale dereliction of the moral direction imposed from above is occurring, which gives cause for optimism. However, this does not adequately address the philosophical issue as to whether or not a less hierarchical approach might not be better.

The role of health education targeting smoking prevention is held by participants to be fifth in ranking the introduced health promotion programmes. This assessment reflects the general public's acknowledgement of the extensive anti-smoking propaganda, leading to a control of smoking prevalence, to only 4% among the population over 15 years of age in 1997, according to the Documentation and Information Centre. This contrasts, for example, with 28% for men and 26% for women in Britain in 1995 (Office for National Statistics, 1997b).

It may also be attributed to the manifestly successful role health education programmes played in paving the way for subsequent legislation. Legislation



included no smoking in the health services, work and public places, schools, and public transport, (although they are not well implemented), and no tobacco publicity (which is well implemented). Nevertheless, in this study only 84% of the public participants mentioned that they do not smoke. This represents a practical application of *McGuire's social inoculation theory*, which is concerned with resistance to social pressure for harmful behaviours.

Critical review of the literature on different nations' experiences, including the UK, USA, Switzerland and Finland, concluded that anti-smoking programmes, especially mass media publicity and school health education, have proven effective in reducing smoking prevalence (at least 5 %), both initially and in the long run, for example (Korhonen, 1993; Nutbeam, 1995, Montazeri et al., 1996 & Stead et al., 1996).

Health officials assessed the role of health education interventions within the other listed health promotion programmes at relatively low rates among all the programmes presented. The role of health education in promoting the safe use of pharmaceuticals ranked sixth, for accident prevention ranked seventh, for promotion of oral health ranked eighth, to encouraging people in the practice of physical exercise ranked ninth, and targeting cardiovascular diseases prevention ranked lowest.

This relative lack of progress in certain areas can probably be attributed to low levels of public education and/or practice in these areas. It may also be attributed to low communication activities, or not well-established national programmes in some of these areas. The impact of a relatively high incidence of accidents and cardiovascular diseases can also lead to this finding.

Nevertheless, 71% of the public participants acknowledged that they had received some information on the adverse effects and/or misuse of pharmaceuticals, and 73% indicated that they now use pharmaceuticals properly. Knowledge on safety rules for the prevention of accidents was seen to have been available to 68%. Seventy-one percent now follow road safety rules. Tooth care



and oral health was appreciated by 81%, and 84% regularly use tooth-paste and brush. Information on the role of personal exercise in health protection was mentioned by 82%, but only 47% practice it. Only 55% indicated that they act on what they know about protection from cardiovascular diseases, and 67% showed that they eat a healthy diet.

These findings are explained by the widely used behaviour change model; *knowledge-attitude-behaviour change*. According to this model, people appear to pass through a series of distinguishable stages before they adopt a new practice. These are; awareness, interest, evaluation, trial and adoption.

Nevertheless, in some issues and with some individuals, knowledge is not necessarily translated to practical application. One possible explanation for this discrepancy is that the knowledge can be held by an individual who does not know how best to express it in behavioural terms. It indicates the need to equip people with the necessary skills through future health education interventions and programmes.

In some other issues, such as personal hygiene, 95% of the public asserted that they looked after their personal hygiene, but only 88% knew the importance of personal hygiene in health protection. The interpretation of this finding is given by the participants themselves when considered the family as the most popular influencing factor in acquiescing in healthy behaviours. Therefore, a number of the participants may have adopted or copied these behaviours without passing through the stages of having specific knowledge or acquiring attitudes. Some of them received the health knowledge from family, friends or peers, and other non-official sources. This finding complies with the social learning theory, in which, it is possible to change behaviours without previously having received knowledge or modified attitudes.

Most Libyan health education programmes are shown by this study as either disease- or risk-factor oriented. Unfortunately, they more closely resemble world wide commonly endorsed health education programmes, rather than health-



oriented health education programmes, despite the national and international improvements in health education techniques in the 1990s.

These findings appear to confirm the author's hypothesis that health education programmes are more successful in maximising parental co-operation in bringing their children forward for vaccination; in improving mothers' knowledge to use oral rehydration fluids and protecting their children from death -as a result of diarrhoea; and in protecting Libyan youth from AIDS.

### **6.3.3 Effectiveness of Health Education Media**

Both the questioned health promotion officials and the questioned public considered TV as the most efficient health education medium, placing it at the top among the presented media. Sixty-seven per cent of the public see TV as one of the major influencing factors in adopting healthy behaviours.

TV in Libya is becoming the most potent of all media, due to the extensive TV coverage and mass audience reaches (UNICEF, 1993a), and the intensive, well designed communications prepared and disseminated by the National Committee for Health and Social Education in collaboration with the Libyan TV channels (Elfituri, 1996c). This finding can also be attributed to the greater authority the material seen in TV carries than the information which is obtained from local sources.

This is in line with several studies which have shown that mass media campaigns promote health knowledge (Maibach et al., 1991), change attitudes (Farquhar, 1977), and may change behaviour (Ershoff et al., 1990), suggesting that simple messages are best understood when they are transmitted visually, as in TV (Chaiken & Eagley, 1976).

Furthermore, one survey in Egypt showed that the vast majority of mothers who knew how to give ORT learned to do so from TV (Foege, 1989). Another study revealed that the TV health and social educational series; *The Family House*



has been watched by almost 95% of the Egyptian adult population, and about 80% of them reported learning health messages as a result (Elkamel, 1995). In Britain the 1992 BBC/HEA 90 minutes *Health Show* TV programme reached 8 million people. Among a sample of people who had written for follow-up materials, 75% reported making long-term changes in life-style (British Market Research Bureau, 1993).

In this study health officials favoured TV programmes over TV spots, while the spots were clearly favoured by the public. People prefer to be reached many times with the same simplified messages through the spots, to serve as a reminder and a reinforcement, than to receive the message all at once within a longer TV programme. Moreover, repeating disseminating messages means more people will be reached.

This finding reflects the relative success in the content of messages chosen and the way in which the spots are designed. This meets the author's hypothesis in considering TV as the most efficient communication medium of health promotion messages.

Supportive results have been shown by several studies. The British Medical Journal (1985) concluded that "the lives of more than 100 000 Egyptian children have been saved as a result of what may be the world's most successful health education campaign, using TV public service announcements in advocating oral rehydration therapy for children suffering from diarrhoea".

In Turkey, 240 000 are estimated to have adopted modern family planning methods as a result of TV dramas and humorous spots (Church & Coller, 1989). Since 1989, UK immunisation rates for childhood diseases have risen rapidly. Of mothers who reported that they saw the 1991 advertisements and took their child to be immunised, 17% cited TV as the major influence on their decision (HEA, 1992).



On the other hand, the public placed family influence as the most potent among the presented influential factors in their practice of healthy life-styles. It was mentioned by 81% of the participants as a crucial element in leading to the adoption of healthy behaviours.

The definite influence of parents and siblings as role models for children in reinforcing healthy behaviours (HEA, 1991b), the internal cohesion of the average Libyan family, and its commitment to Islamic precepts, render these influences pivotal. They address personal hygiene and physical exercise, oral health, healthy food, breast-feeding, no smoking or alcohol drinking, and abstention from sexual activities between unmarried couples.

Public evaluation of radio health education role in promoting health does not meet with the health promotion officials' predictions. Both radio programmes and spots were ranked by the officials as third and fourth respectively, among the introduced media after the TV programmes and spots. The general public participants ranked the role of radio programmes and spots in raising health knowledge as fifth and sixth respectively, favouring books, magazines and newspapers as third and school health education as fourth. However, 58%, 52% and 36% of the public have selected reading books, magazines and newspapers respectively as influencing factors for them to achieve practising healthy behaviours, and school curricula was mentioned by 54%, whereas radio is indicated by only 39%. This finding contradicts the author's hypothesis in assuming the school health education not to be considered very effective.

This diverges from the expectations of the health officials as well who held these channels of health education to be least on the list of educational media presented.

On the other hand, the low sales of *Al-Manara*, the public health education magazine -which has been assessed by the Regional Office of WHO as one of the best in the region, compared with the sales of other different magazines (Elfituri,



1995)- supports the opinion of health officials on the low influence of print health education materials on the Libyan people.

The varied health promotion national and local programmes provide people with several health promotion messages, using different ways and techniques through the different national and local radio stations. This great work is assumed to be a highly efficient channel of educating the Libyan community.

Nevertheless, increased literacy rates in the country (LSMCH, 1997) encourages Libyans to rely more on books, magazines and newspapers, as well as school health education. This is a positive finding, in that it clearly makes more sense to encourage young people to adopt healthy life-styles than to attempt to change unhealthy behaviour patterns in adulthood (Angela, 1996). It is in line with the general agreement that schools are a key setting for the promotion of health (DOH, 1992; Naidoo & Wills, 1997).

Booklets and leaflets are seen by the general public as the least effective health knowledge communicating medium, and are mentioned by only 21% as having an influence in practising healthy behaviours.

Officials have over-estimated the efficiency of posters as a medium of health education. They rated them as fifth. However, public participants put them at the eighth place with regard to their role in raising health knowledge among the employed health education media. Only 29% of the public sample regarded posters as one of their favoured sources of influence in adopting healthy behaviours. The interpretation of this finding is clearly mentioned by Park and Park (1997). They said in their book *Park's Textbook of Preventive and Social Medicine*; "As a medium of health education, posters have much less effect in changing behaviours than the enthusiastic users would hope". As well, this result may indicate that the educational posters issued by the different health authorities do not meet people's needs, or they are not well distributed over the country.



Lectures, symposia and the mosques are seen by both the officials and the public at nearly the same level of effectiveness and influence as posters. Nevertheless, this method of communication is mostly one-way. There is no way for the group to participate actively in learning, hence it may fail to influence the health behaviour of people.

Moreover, this finding may mean that group health education approach, particularly the mosque's role, is not well employed in Libya, especially if compared with some other countries in the region, in which the mosque had the added effect of lending important credibility to the immunisation programme (UNICEF, 1993a). Islam calls the faithful to undertake healthy behaviours and keep away from unhealthy ones.

The activity of mosques in promoting the community health can be supported in the direction of a healthy life-style from the religious point of view, emphasising the prevention of AIDS and other sexually transmitted diseases, smoking, alcohol and drugs prevention; breast-feeding and immunisation; accidents prevention; and hygiene.

Friends are seen by 37% of the public participants, and peers and colleagues by 24%, as influencing elements in practising healthy life-styles. Several studies show that friends and peers exert a considerable influence in peoples' lives (Hafstad, 1996), and it would appear that peers and friends are of central importance to young people (HEA, 1991a).

The only explanation for the relatively low percentage of participants indicating friends, colleagues and peers is that only 14% of the sample is under 20 years of age. Within this group, 50% selected friends and 31% selected peers and colleagues as sources of influence for healthy behaviours. Possibly, friends' and peers' influence is more towards unhealthy behaviours than healthy ones.

Both the questioned public and the official participants converge in their assessment of the role of health professionals in health education at low levels (the



eighth by the officials and seventh by the public). This meets the author's hypothesis in assuming that health professionals are a much less important source of health knowledge, and are of minor effectiveness as influencing factors for promoting healthy behaviours.

A previous survey indicated that the general public most often turn to their general practitioner as their principle source of medical information. It has also been shown that patients generally approve of the role of the general practitioner as health educator (Wood et al., 1989).

Furthermore, there is a high level of motivation amongst general practitioners towards health education of their patients and, equally, considerable honesty about the difficulties they encounter in carrying this out. Although 95% of the randomly selected and interviewed general practitioners in a study agreed that patient education was important, and 61% placed doctors' advice in the top three most effective methods of communicating health advice, 92% had encountered practical difficulties involving poor doctor-patient communication. Seventy-six per cent of doctors highlighted lack of time as a barrier to providing more health advice for their patients and 54% said that time constraints were a major difficulty in their practices (Tapper-Jones et al., 1990).

Boulton and Williams (1986) said in this context: "the general practitioners approached the work of general practice in a way which is likely to inhibit them from putting their knowledge of health education and prevention in practice. They were largely disease-oriented, took a relatively narrow view of health education, and felt so constrained by circumstances as to respond to the presenting problem only.

This finding would therefore, suggest that some health professionals have difficulties which prevent them from providing adequate education for their clients. These difficulties, which may be organisational, attitudinal or due to deficiencies in health promotion knowledge or communication skills, need identification before



further planning of health education and promotion programmes in primary care can be carried out.

Part Three of the present research examines the health professionals' perceptions about their role in health education, in order to identify the main barriers and suggest actions for improving the service.



**CHAPTER SEVEN**  
**(PART TWO)**  
**ASSESSMENT OF FUTURE**  
**NEEDS**



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## **CHAPTER SEVEN (PART TWO)**

### **ASSESSMENT OF FUTURE NEEDS**

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#### **7.1 METHOD**

##### **7.1.1 Study Population:**

Similar to the first part of this research, two designs of an open-end questionnaire were formulated in this part. These two designs were handed out to two different groups of participants. They are the health education/promotion officials and the general public (providers and users). The first design of the questionnaire targeted the members of the National Committee for Health and Social Education, the members of the National Advisory Board for Primary Health Care, the members of Primary Health Care Central administration, the directors of Departments of Primary Health Care and Health Education at the districts level, the managers and experts of public health programmes, and the under-secretaries of health in Libya for the period of 30 years. The second design of the questionnaire targeted a sample representative of the general public.

##### **7.1.2 Research Questions**

The two different groups were questioned about health issues and groups of people, which, and to whom, future health education programmes should address and to be directed. They were requested to indicate which of the media have to be employed for each issue and each group of people. As well, both the groups were requested to report their recommendations and suggestions for future planning of health education programmes. A list of 30 health issues, 18 target groups and 34 educational media were presented as guiding examples for the participants (see Appendix C, page 380 and Appendix D, page 384).



### **7.1.3 Variables**

Variables in the officials' design included current occupation, gender and leading qualification. In the general public design, age was also included, in addition to the officials' design variables.

### **7.1.4 Piloting and Procedure**

The questionnaire draft was, first, revised by the Regional Adviser for Health Situation and Trend Assessment, Eastern Mediterranean Region of the World Health Organisation, who made some suggestions and recommendations. The questionnaire was then piloted to representative samples of the targeted groups. The design targeting the officials was piloted to ten people, including the members of the National Committee for Health and Social Education and the members of the National Board for Primary Health Care. The general public design was piloted to 50 subjects. Modifications were made according to the samples' comments. 60 copies of the first design were handed out, during 1999, to the officials, at both national and local levels of the country. 300 copies were handed, during 1999 and 2000, to a sample representative of the general public configuration. The questionnaire was administered to the study participants personally, with the aid of colleagues, friends and family members, in face to face settings, during social meetings or events, or in schools or work places. The purpose of the study was explained and the questionnaires could be completed on the spot or personally collected later.

Similar suggested target groups indicated by study participants were grouped by the author. For example visitors to primary health care centres; maternal & child health units; pregnant women clinics; teeth & oral health clinics; out-patient clinics in hospitals; and so on, were grouped together in a group named 'visitors to health services'.

The same procedure was followed with recommended educational media. TV spots, TV programmes, TV documentary films, and TV children programmes



were put in one group, namely TV. The same applies to radio. Education channels of similar features and approach were put together. This was so in the cases of lectures & seminars; newspapers & magazines; and booklets & leaflets.

The higher frequency for indicated health issues, suggested target groups and recommended educational media is the higher priority and preference among the others.

7.2 RESULTS

7.2.1 First Questionnaire (Health Officials Group)

7.2.1.1 Response rate

Out of the 60 targeted officials, 52 returned the questionnaire (response rate is 86.7%), as per Table 7.1.

No. of targeted officials	No. of respondents	Percentage
60	52	86.7

Table 7.1: Number of targeted officials, number of respondents and response rate.

7.2.1.2 Description of the participants

Tables 7.2, 7.3 and 7.4 show the description of the participants according to their gender, occupation and leading qualification respectively.

Gender	No. of participants
Male	46
Female	6
Total	52

Table 7.2: Official participants according to their gender.



Occupation	No. of participants
Ex-Under Secretary of Health	5
Member of the National Committee for Health & Social Education	10
Member of the National Advisory Board for Primary Health Care/ Member of the Central Primary Health Care Administration	8
Manager/Member of Public Health Central Programmes	16
Director of Health Education/Primary Health Care at Local Districts	9
National Consultant/Advisor	4
Total	52

Table 7.3: Official participants according to their occupation.

Leading Qualification	No. of Participants
Intermediate Diploma	7
BSc or equivalent	13
MSc or equivalent	11
PhD or equivalent	21
Total	52

Table 7.4: Official participants according to their leading qualification.



7.2.1.3 Indicated priority health issues by health officials

Rank order of the indicated health issues according to their frequency, within the completed and received copies, is shown in Table 7.5. It also shows the percentage of participants who indicated each health issue, out of the total number of participants.

Priority Number	Health Issues	No. of Participants (n=52)	%
1	Personal Hygiene, Sanitation & Environmental Health	29	55.77
2	Immunisation	23	44.23
3	Healthy Food & Proper Nutrition	20	38.46
4	Child Health	19	36.54
4	Maternal Health	19	36.54
6	AIDS Control	17	32.69
6	Accident Prevention	17	32.69
6	Child Health During School Age/School Health	17	32.69
9	Breast-feeding	16	30.77
10	Drug Abuse Control	14	26.92
11	Smoking Prevention	12	23.08
12	Regular Medical Check-up	10	19.23
13	Safe Use of Medications	9	17.31
13	Teeth & Oral Health	9	17.31



15	Prevention of Cardiovascular Diseases	8	15.38
16	Prevention of Cancers	6	11.54
16	Control of Communicable & Endemic Diseases	6	11.54
18	Sport & Physical Exercise	4	7.69
18	Family Planning	4	7.69
18	First Aid	4	7.69
18	Control of Diarrhoeal Diseases	4	7.69
18	Prevention of Eye Diseases & Blindness	4	7.69
23	Diabetes Control	3	5.77
23	Occupational Health	3	5.77
25	Mental & Psychiatric Health	2	3.85
26	Family Health	1	1.92
26	Perinatal Period Care	1	1.92
26	Relatives Marriage	1	1.92
26	Hepatitis-B Control	1	1.92
26	Obesity Control	1	1.92
26	Stress Control	1	1.92
26	Utilisation of Health Services	1	1.92
Total no. of indicated health issues =32			

Table 7.5: Rank order of health issues according to their frequency.



#### 7.2.1.4 Suggested target groups by health officials

Table 7.6 shows the suggested target groups for each indicated health issue together with the number of participants expressed as a percentage of who indicated each particular health issue.

Indicated Health Issues	No	Suggested Target Groups	No	%
1- Personal Hygiene, Sanitation & Environmental Health	29	All public groups	19	65.52
		Youth	12	41.38
		Children	8	27.59
		Students	7	24.14
		Mothers/House wives	6	20.69
		Industry labour	5	17.24
		Workers at environmental health field	4	13.79
		Parents/Patrons	3	10.34
		Adult generation	2	6.90
		Pastries/Bakers/Catering labour	2	6.90
		Scouts	1	3.45
		Hoteling labour	1	3.45
		Incoming labour	1	3.45
2- Immunisation	23	Parents/Patrons	11	47.83
		School children	11	47.83



		Mothers	7	30.43
		All public groups	6	26.09
		Women/Female youth	3	13.04
		Health services' visitors	3	13.04
		Under 6-children	2	8.70
		Female teachers	1	4.35
		N.G.Os/Women societies	1	4.35
		Fathers	1	4.35
		Youth	1	4.35
3- Healthy Food & Proper Nutrition	20	All public groups	13	65.00
		School children/Students	10	50.00
		Mothers	9	45.00
		Youth	5	25.00
		Housewives	3	15.00
		Fathers	3	15.00
		Under 6-children	3	15.00
		Diabetics	3	15.00
		Female youth	2	10.00
		Health services visitors	2	10.00
		Aged population	1	5.00
		Military personnel	1	5.00



4- Child Health	19	Parents/Patrons	10	52.63
		Mothers	9	47.37
		School children	7	36.84
		Health services visitors	4	21.05
		Teachers	3	15.79
		Female youth	3	15.79
		Under 6-children	3	15.79
		All public groups	2	10.53
		Youth	2	10.53
		Fathers	1	5.26
4- Maternal Health	19	Female youth	9	47.37
		Mothers	7	36.84
		Married couples	5	26.32
		Health services visitors	4	21.05
		Women	3	15.79
		Pregnant mothers	2	10.53
		Youth	2	10.53
		All public groups	1	5.26
		Teachers	1	5.26
		Husbands	1	5.26
6- AIDS Control	17	Youth	14	82.35



		Adult Students	7	41.18
		All public groups	7	41.18
		School children	4	23.53
		Female youth	2	11.77
		Policemen/Military personnel	2	11.77
		Adult generation	1	5.88
		Women	1	5.88
		Mothers	1	5.88
		Health services' visitors	1	5.88
		Travellers	1	5.88
		Barbers	1	5.88
		Prisoners	1	5.88
		HIV infected patients	1	5.88
6- Accident Prevention	17	Youth	9	52.94
		All public groups	7	41.18
		School children	6	35.29
		Parents/Patrons	4	23.53
		Industry/Construction labour	4	23.53
		Students	2	11.76
		Vehicles drivers	2	11.76
		Mothers	1	5.88



		Traffic police	1	5.88
		Neurotic/Psychotic patients	1	5.88
		Electricity workers	1	5.88
		Adult population	1	5.88
6- Child Health During School Age/School Health	17	School children	16	94.12
		Teachers	12	70.59
		Parents/Patrons	8	47.06
		Family	1	5.88
		School health officers	1	5.88
9- Breast-feeding	16	Mothers/Pregnant mothers	13	76.47
		Female youth	6	35.29
		Health services visitors	4	23.53
		Married couples	2	11.76
		Youth	2	11.76
		Post delivery mothers (in hospitals)	1	5.88
		All public groups	1	5.88
10- Drug Abuse Control	14	Teenagers/Youth	12	85.71
		Students	8	57.14
		All public groups	6	42.86
		Parents	5	35.71



		Teachers	2	14.29
		Policemen	2	14.29
		Youth/N.G.Os' members	1	7.14
		Prisoners/Prison guards	1	7.14
		Smokers	1	7.14
11- Smoking Prevention	12	School children/Students	11	91.67
		All public groups	6	50.00
		Parents/Patrons	2	16.67
		Mothers	2	16.67
		Teachers	1	8.33
12- Regular Medical Check-up	10	All public groups	4	40.00
		Aged population/People over 40	4	40.00
		School children/Students	3	30.00
		Parents/Patrons	2	20.00
		Mothers	2	20.00
		Industry labour	2	20.00
		Youth	1	10.00
		Smokers	1	10.00
		Families of disease history	1	10.00



13- Safe Use of Medications	9	All public groups	8	88.89
		Youth	4	44.44
		Parents	3	33.33
		Health services'/Pharmacies' visitors	3	33.33
		School children	2	22.22
		Mothers	2	22.22
		Aged population	1	11.11
		Patients of chronic diseases	1	11.11
13 Teeth & Oral Health	9	Students/School children	8	88.89
		Mothers	5	55.56
		All public groups	4	44.44
		Youth	4	44.44
		Parents	2	22.22
		Adult generation	1	11.11
15- Prevention of Cardiovascular Diseases	8	Youth	5	62.50
		Aged population/People over 40	3	37.50
		All public groups	2	25.00
		Students	2	25.00
		Housewives	2	25.00
		Employees/Officers/	2	25.00



		Sedentary professionals		
		Adult generation	1	12.50
		At risk groups	1	12.50
16- Prevention of Cancers	6	All public groups	2	33.33
		Women	2	33.33
		Youth	2	33.33
		Industry labour	2	33.33
		Health services' visitors	1	16.67
		Mothers	1	16.67
		Women societies	1	16.67
		Adult generation	1	16.67
		Aged population	1	16.67
		Cancer patients	1	16.67
16- Control of Communicable & Endemic Diseases	6	All public groups	3	50.00
		Youth	2	33.33
		Students	1	16.67
		Teachers	1	16.67
		Inhabitants of at risk areas	1	16.67
		Parents	1	16.67
		Health services' visitors	1	16.67
		Children	1	16.67



18- Sport & Physical Exercise	4	School children	2	50.00
		Youth	2	50.00
		Diabetics	2	50.00
		All public groups	1	25.00
		Adult generation	1	25.00
		Mothers	1	25.00
		Smokers	1	25.00
		Aged population	1	25.00
		Employees at work places	1	25.00
		Military personnel	1	25.00
18- Family Planning	4	Married couples	3	75.00
		Youth	2	50.00
		Health services visitors	1	25.00
		Mothers	1	25.00
		Men	1	25.00
18- First Aid	4	All public groups	2	50.00
		Youth	2	50.00
		Students	1	25.00
		Teachers	1	25.00
		Housewives	1	25.00



		Public security personnel	1	25.00
18- Control of Diarrhoeal Diseases	4	Mothers	2	50.00
		Parents	1	25.00
		Health services' visitors	1	25.00
		Children	1	25.00
18- Prevention of Eye Diseases & Blindness	4	All public groups	3	75.00
		Students	2	50.00
		Industry labour	2	50.00
		Aged population	1	25.00
		Diabetics	1	25.00
		Inhabitants of rural areas	1	25.00
23- Diabetes Control	3	All public groups	2	66.66
		Youth	1	33.33
		Adult generation	1	33.33
23- Occupational Health	3	Industry labour/ Handicraftsmen	3	100.00
		Farmers	2	66.66
25- Mental & Psychiatric Health	2	Youth	2	100.00
		All public groups	1	50.00



		Teachers	1	50.00
		Aged population	1	50.00
		Sick people	1	50.00
26- Family Health	1	Youth at marriage age	1	100.00
26- Perinatal Period Care	1	Mothers	1	100.00
		Fathers	1	100.00
		Grandmothers	1	100.00
		Youth	1	100.00
26- Relatives Marriage	1	Youth	1	100.00
		Women societies	1	100.00
26- Hepatitis-B Control	1	Students/Youth	1	100.00
		Parents/Patrons	1	100.00
		N.G.Os	1	100.00
		Prisoners/Prison guards	1	100.00
26- Obesity Control	1	Children	1	100.00
		Youth	1	100.00
		Adult generation	1	100.00



26- Stress Control	1	All public groups	1	100.00
		Desk employees	1	100.00
26- Utilisation of Health Services	1	All public groups	1	100.00

Table 7.6: Suggested target groups for each health issue.



### 7.2.1.5 Recommended educational media

Tables 7.7 to 7.38 show the recommended educational media for each of the suggested target groups for each particular health issue, together with the number of participants recommended each of the media, also expressed as a percentage of who indicated the concerned health issue.

Table 7.7: Recommended educational media for each of the suggested target groups for the first priority health issue (Personal Hygiene, Sanitation & Environmental Health; n=29).

Suggested Target Group	No	Recommended Educational Media	No	% (n=29)
All public groups	19	TV	16	55.17
		Radio	13	44.83
		Booklets/Leaflets	7	24.14
		Youth/Sport clubs	6	20.69
		Mosques	6	20.69
		Posters	5	17.24
		Lectures/Seminars	4	13.79
		Books	3	10.34
		Schools	2	6.90
		Newspapers/Magazines	2	6.90
		Health professionals	1	3.45
		Mobile educational teams	1	3.45
		Military camps	1	3.45



Youth	12	TV	7	24.14
		Youth/Sport clubs	6	20.69
		Booklets/Leaflets	5	17.24
		Lectures/Seminars	4	13.79
		Posters	4	13.79
		Radio	4	13.79
		Schools/Universities	3	10.34
		Newspapers/Magazines	2	6.90
		Mosques	1	3.45
		Mobile educational teams	1	3.45
		Role models in TV	1	3.45
Children	8	School curricula	6	20.69
		TV	6	20.69
		Mobile educational teams	2	6.90
		School activities		3.45
		Parents	1	3.45
		Family	1	3.45
		Teachers	1	3.45
		Teachers as role models	1	3.45
		Summer clubs	1	3.45



Students	7	School curricula	5	17.24
		Booklets/Leaflets	4	13.79
		Lectures/Seminars	3	10.34
		Youth/Sport clubs	2	6.90
		TV	2	6.90
		Radio	1	3.45
		Scouts	1	3.45
		Posters	1	3.45
Mothers/Housewives	6	TV	5	17.24
		Radio	3	10.34
		Booklets/Leaflets	3	10.34
		Home visits	2	6.90
		Women societies	1	3.45
		Mobile educational teams	1	3.45
		Newspapers/Magazines	1	3.45
Industry labour	5	Posters	3	10.34
		TV	2	6.90
		Mobile educational teams	2	6.90
		Radio	1	3.45
		Lectures/Seminars	1	3.45
		Booklets/Leaflets	1	3.45



Workers at environmental health field	4	Lectures/Seminars	3	10.34
		Booklets/Leaflets	2	6.90
		TV	2	6.90
		Radio	1	3.45
		Posters	1	3.45
Parents/Patrons	3	TV	3	10.34
		Radio	3	10.34
		Booklets/Leaflets	2	6.90
		Posters	2	6.90
		Mobile educational teams	1	3.45
		Home visits	1	3.45
		Patrons School board	1	3.45
Adult generation	2	Mosques	2	6.90
		TV	1	3.45
		Radio	1	3.45
Pastries/Bakers/ Catering labour	2	TV	1	3.45
		Newspapers/Magazines	1	3.45
		Mobile educational teams	1	3.45
		Council officers	1	3.45



Scouts	1	TV	1	3.45
		Radio	1	3.45
		Newspapers/Magazines	1	3.45
		Booklets/Leaflets	1	3.45
Hoteling labour	1	Mobile educational teams	1	3.45
Incoming labour	1	Booklets/Leaflets	1	3.45
		Mobile educational teams	1	3.45
		Council officers	1	3.45

Table 7.8: Recommended educational media for each of the suggested target groups for the second priority health issue (Immunisation; n=23).

Suggested Target Group	No	Recommended Educational Media	No	% (n=23)
Parents/Patrons	11	TV	7	30.43
		Booklets/Leaflets	6	26.09
		Radio	5	21.74
		Posters	3	13.04
		Lectures/seminars	3	13.04
		Home visits	1	4.35
		Patrons school board	1	4.35
		Newspapers/Magazines	1	4.35
		Health services	1	4.35



School children	11	School curricula	8	34.78
		TV	8	34.78
		Radio	4	17.39
		Booklets/Leaflets	4	17.39
		School visits	2	8.70
		Teachers	1	4.35
		Lectures/Seminars	1	4.35
		Posters	1	4.35
		Home visits	1	4.35
Mothers	7	TV	6	26.09
		Radio	6	26.09
		Health professionals	2	8.70
		Health services	2	8.70
		Mobile educational teams	2	8.70
		Home visits	1	4.35
		Social workers	1	4.35
		Female gathering places	1	4.35
		Posters	1	4.35
		Lectures/Seminars	1	4.35
		Books	1	4.35



All public groups	6	TV	5	21.74
		Radio	4	17.39
		Booklets/Leaflets	4	17.39
		Health centres	1	4.35
		Posters	1	4.35
		Mosques	1	4.35
		Newspapers/Magazines	1	4.35
Women/Female youth	3	TV	3	13.04
		Radio	3	13.04
		Health professionals	1	4.35
		Posters	1	4.35
Health services' visitors	3	Lectures/Seminars	3	13.04
		Booklets/Leaflets	1	4.35
		Mobile educational teams	1	4.35
Under 6-children	2	TV	2	8.70
		Home visits	1	4.35
		Posters	1	4.35
		Booklets/Leaflets	1	4.35



Female teachers	1	TV	1	4.35
		Nursery schools	1	4.35
		Preparatory/Primary schools	1	4.35
N.G.Os & Women societies	1	TV	1	4.35
		Radio	1	4.35
		Booklets/Leaflets	1	4.35
		Newspapers/Magazines	1	4.35
				4.35
Fathers	1	TV	1	4.35
		Radio	1	4.35
		Lectures/Seminars at work places	1	4.35
Youth	1	TV	1	4.35
		Youth/Sport clubs	1	4.35
		Scouts/Red crescent members	1	4.35

Table 7.9: Recommended educational media for each of the suggested target groups for the third priority health issue (Healthy Food & Proper Nutrition; n=20).

Suggested Target Group	No	Recommended Educational Media	No	% (n=20)
All public groups	13	TV	12	60.00
		Radio	10	50.00



		Booklets/Leaflets	7	35.00
		Newspapers/Magazines	3	15.00
		Lectures/Seminars	3	15.00
		Mosques	2	10.00
		Posters	2	10.00
		Books	1	5.00
		Mobile educational teams	1	5.00
School children/Students	10	School curricula	7	35.00
		Teachers	4	20.00
		TV	3	15.00
		School activities	2	10.00
		Posters	2	10.00
		Radio	1	5.00
		Lectures/Seminars	1	5.00
		Booklets/Leaflets	1	5.00
		School visits	1	5.00
		Social workers	1	5.00
Mothers	9	TV	7	35.00
		Booklets/Leaflets	5	25.00
		Radio	3	15.00
		Health centres	2	10.00



		Newspapers/Magazines	2	10.00
		Health professionals	1	5.00
		Home visits	1	5.00
		Mobile educational teams	1	5.00
		Posters	1	5.00
		Lectures/Seminars	1	5.00
Youth	5	TV	4	20.00
		Youth/Sport clubs	4	20.00
		Lectures/Seminars	3	15.00
		Radio	1	5.00
		Newspapers/Magazines	1	5.00
		Schools/Universities	1	5.00
Housewives	3	TV	2	10.00
		Radio	2	10.00
		Newspapers/Magazines	2	10.00
		Women societies	1	5.00
		Lectures/Seminars	1	5.00
		Booklets/Leaflets	1	5.00
Fathers	3	TV	3	15.00
		Radio	2	10.00



		Booklets/Leaflets	2	10.00
		Newspapers/Magazines	1	5.00
		Health centres	1	5.00
		Lectures/Seminars	1	5.00
Under 6-children	3	Nursery schools	2	10.00
		Mothers	1	5.00
		Posters	1	5.00
		Social workers	1	5.00
Diabetics	3	Booklets/Leaflets	2	10.00
		Lectures/Seminars	2	10.00
		TV	1	5.00
		Home visits	1	5.00
Female youth	2	TV	2	10.00
		Radio	2	10.00
		School curricula	2	10.00
		Booklets/Leaflets	2	10.00
Health services' visitors	2	Booklets/Leaflets	2	10.00
		Posters	1	5.00
		Lectures/Seminars	1	5.00



Aged population	1	TV	1	5.00
		Posters	1	5.00
		Booklets/Leaflets	1	5.00
Military personnel	1	Lectures/Seminars	1	5.00
		Posters	1	5.00

Table 7.10: Recommended educational media for each of the suggested target groups for the fourth priority health issue (Child Health; n=19).

Suggested Target Group	No	Recommended Educational Media	No	% (n=19)
Parents	10	TV	9	47.37
		Booklets/Leaflets	6	31.58
		Radio	3	15.79
		Home visits	2	10.53
		Posters	2	10.53
		Newspapers/Magazines	2	10.53
		Books	2	10.53
		Lectures/Seminars	2	10.53
		Health professionals	1	5.26
		Mosques	1	5.26
		Mobile educational teams	1	5.26
		Health services	1	5.26



Mothers	9	TV	9	47.37
		Radio	9	47.37
		Health professionals	3	15.79
		Women clubs/gathering places	3	15.79
		Health services	2	10.53
		Home visits	2	10.53
		Social workers	2	10.53
		Booklets/Leaflets	2	10.53
		Posters	2	10.53
		Lectures/Seminars	2	10.53
		Women societies	1	5.26
School children	7	School curricula	4	21.05
		TV	3	15.79
		Radio	2	10.53
		Teachers	2	10.53
		Social workers	2	10.53
		Posters	2	10.53
		School activities	1	5.26
		Mobile educational teams	1	5.26
		Booklets/Leaflets	1	5.26
		Family	1	5.26



		Health services	1	5.26
Health services' visitors	4	Booklets/Leaflets	3	15.79
		Videos	3	15.79
		Posters	2	10.53
		Lectures/Seminars	2	10.53
		Health professionals	1	5.26
Teachers	3	Lectures/Seminars	3	15.79
		Booklets/Leaflets	2	10.53
		TV	1	5.26
		Radio	1	5.26
Female youth	3	Schools/Universities	3	15.79
		School curricula	2	10.53
		School activities	1	5.26
		TV	1	5.26
		Radio	1	5.26
		Booklets/Leaflets	1	5.26
		Mother/Grandmother	1	5.26
Under 6-children	3	Nursery schools	3	15.79
		TV	2	10.53



		Radio	2	10.53
		Posters	2	10.53
		Home visits	1	5.26
		Nursery school care providers	1	5.26
		Social workers	1	5.26
		Booklets/Leaflets	1	5.26
All public groups	2	TV	2	10.53
		Radio	1	5.26
		Books	1	5.26
		Booklets/Leaflets	1	5.26
Youth	2	School curricula	2	10.53
		TV	1	5.26
		Radio	1	5.26
		Health professionals	1	5.26
Fathers	1	TV	1	5.26
		Radio	1	5.26
		Lectures/Seminars at work places	1	5.26



Table 7.11: Recommended educational media for each of the suggested target groups for the equal forth priority health issue (Maternal Health; n=19).

Suggested Target Group	No	Recommended Educational Media	No	% (n=19)
Female youth	9	TV	5	26.32
		Booklets/Leaflets	5	26.32
		Radio	4	21.05
		School curricula	4	21.05
		Lectures/Seminars in schools/universities	4	21.05
		School activities	2	10.53
		Women societies	2	10.53
		School visits	1	5.26
		Posters	1	5.26
		Mother/Grandmother	1	5.26
Mothers	7	TV	7	36.84
		Radio	7	36.84
		Health professionals	3	15.79
		Health services	2	10.53
		Home visits	2	10.53
		Women clubs/gathering places	2	10.53
		Booklets/Leaflets	2	10.53
		Lectures/Seminars	2	10.53



		Posters	1	5.26
Married couples	5	TV	5	26.32
		Radio	4	21.05
		Posters	2	10.53
		Booklets/Leaflets	2	10.53
		Health professionals	1	5.26
		Health services	1	5.26
		Mosques	1	5.26
		Books	1	5.26
		Newspapers/Magazines	1	5.26
Health services' visitors	4	Health professionals	3	15.79
		Videos	3	15.79
		Booklets/Leaflets	3	15.79
		Lectures/Seminars	2	10.53
		Posters	1	5.26
Women	3	TV	3	15.79
		Radio	2	10.53
		Booklets/Leaflets	2	10.53
		Home visits	1	5.26
		Posters	1	5.26



		Newspapers/Magazines	1	5.26
		Lectures/Seminars	1	5.26
Pregnant mothers	2	TV	1	5.26
		Radio	1	5.26
		Posters	1	5.26
		Booklets/Leaflets	1	5.26
Youth	2	TV	1	5.26
		School	1	5.26
		Cinema/Theatre	1	5.26
		Booklets/Leaflets	1	5.26
		Lectures/Seminars	1	5.26
All public groups	1	TV	1	5.26
		Radio	1	5.26
		Booklets/Leaflets	1	5.26
Teachers	1	TV	1	5.26
		Radio	1	5.26
		Lectures/Seminars	1	5.26
		Booklets/Leaflets	1	5.26



Husbands	1	TV	1	5.26
		Radio	1	5.26
		Lectures/Seminars	1	5.26
		At work places		

Table: 7.12 Recommended educational media for each of the suggested target groups for the sixth priority health issue (AIDS Control; n=17).

Suggested Target Group	No	Recommended Educational Media	No	% (n=17)
Youth	14	TV	12	70.59
		Radio	9	52.94
		Youth/Sport clubs	9	52.94
		Booklets/Leaflets	8	47.06
		Mosques	3	17.65
		Lectures/Seminars	2	11.76
		Newspapers/Magazines	2	11.76
		Schools/Universities	2	11.76
		Posters	2	11.76
		N.G.Os	1	5.88
		Scouts	1	5.88
		Internet	1	5.88
		Books	1	5.88
		Educational exhibitions	1	5.88



Adult students	7	School curricula	7	41.18
		TV	6	35.29
		Radio	3	17.65
		Posters	3	17.65
		Booklets/Leaflets	3	17.65
		Mosque	1	5.88
		Cinema/Theatre	1	5.88
		N.G.Os	1	5.88
All public groups	7	TV	7	41.18
		Radio	5	5.88
		Mosques	4	29.41
		Booklets/Leaflets	4	23.53
		Posters	3	23.53
		Lectures/Seminars	2	17.65
		Cinema/Theatre	1	11.76
		Social workers	1	5.88
		Newspapers/Magazines	1	5.88
		Confidential tel. line for people suspicious of infection	1	5.88
School children	4	School curricula	3	5.88
		TV	2	17.65



		Mosques	1	11.76
		Lectures/Seminars	1	5.88
		Booklets/Leaflets	1	5.88
Female youth	2	TV	1	5.88
		Radio	1	5.88
		Female youth clubs/gathering places	1	5.88
		Lectures/Seminars at schools/universities	1	5.88
Policemen/ Military personnel	2	Mobile educational team	1	5.88
Adult generation	1	TV	1	5.88
		Mosque	1	5.88
		Booklets/Leaflets	1	5.88
Women	1	TV	1	5.88
		Radio	1	5.88
		Women societies	1	5.88
		Posters	1	5.88
Mothers	1	Videos at health services	1	5.88



		Lectures	1	5.88
Health services' visitors	1	Videos	1	5.88
		Posters	1	5.88
		Booklets/Leaflets	1	5.88
Travellers	1	Booklets/Leaflets	1	5.88
Barbers	1	Mobile educational teams	1	5.88
Prisoners	1	Lectures/Seminars	1	5.88
		Booklets/Leaflets	1	5.88
HIV infected patients	1	TV	1	5.88
		Radio	1	5.88
		Booklets	1	5.88

Table 7.13: Recommended educational media for each of the suggested target groups for the equal sixth priority health issue (Accident Prevention; n=17).

Suggested Target Group	No	Recommended Educational Media	No	% (n=17)
Youth	9	TV	5	29.41
		Lectures	5	29.41
		Radio	3	17.65



		Booklets/Leaflets	2	11.76
		School curricula	1	5.88
		Cinema/Theatre	1	5.88
		Posters	1	5.88
		Traffic week campaign	1	5.88
All public groups	7	TV	5	29.41
		Radio	3	17.65
		Posters	2	11.76
		Teachers	1	5.88
		Traffic police	1	5.88
		Mosques	1	5.88
		Booklets/Leaflets	1	5.88
		Newspapers/Leaflets	1	5.88
School children	6	TV	5	29.41
		School curricula	4	23.53
		Radio	2	11.76
		School activities	1	5.88
		Teachers	1	5.88
		Participation in traffic week campaign	1	5.88
		Family	1	5.88



		Booklets/Leaflets	1	5.88
		Posters	1	5.88
Parents/Patrons	4	TV	4	23.53
		Radio	4	23.53
		Booklets/Leaflets	3	17.65
		Posters	2	11.76
		Health services	1	5.88
		Books	1	5.88
Industry/Construction labour	4	TV	2	11.76
		Radio	2	11.76
		Posters	2	11.76
		Booklets/Leaflets	2	11.76
		Lectures/Seminars	2	11.76
		Health professionals	1	5.88
Students	2	Lectures/Seminars	2	11.76
		TV	1	5.88
		Radio	1	5.88
		Booklets/Leaflets	1	5.88
Vehicles' drivers	2	TV	2	11.76



		Radio	1	5.88
Mothers	1	TV	1	5.88
		Radio	1	5.88
		Home visits	1	5.88
		Mobile educational teams	1	5.88
Traffic police	1	Lectures/Seminars	1	5.88
Patients with psychiatric illnesses or neurological disorders	1	Booklets	1	5.88
				5.88
Electricity workers	1	Lectures/Seminars	1	5.88
				5.88
Adult population	1	TV	1	5.88
		Radio	1	5.88
		Mosque	1	5.88
		Booklets/Leaflets	1	5.88
Aged population	1	TV	1	5.88
		Radio	1	5.88
		Home visits	1	5.88



		Family	1	5.88
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Table 7.14: Recommended educational media for each of the suggested target groups for the equal sixth priority health issue (Child Health During School Age/School Health; n=17).

Suggested Target Group	No	Recommended Educational Media	No	% (n=17)
School children	16	School curricula	11	64.71
		TV	8	47.06
		Teachers	5	29.41
		Radio	4	23.53
		School activities	3	17.65
		Lectures/Seminars	3	17.65
		Posters	3	17.65
		Booklets/Leaflets	3	17.65
		School visits	2	11.76
		Internet	1	5.88
		Health professionals	1	5.88
		Videos	1	5.88
Teachers	12	Lectures/Seminars	11	64.71
		Booklets/Leaflets	4	23.53
		TV	4	23.53
		Posters	2	11.76
		Radio	2	11.76



		Newspapers	1	5.88
		Mobile educational teams	1	5.88
Parents/Patrons	8	TV	6	35.29
		Radio	6	35.29
		Health professionals	3	17.65
		Posters	3	17.65
		Books	2	11.76
		Booklets/Leaflets	1	5.88
		Patrons school board	1	5.88
		Newspapers/Magazines	1	5.88
Family	1	TV	1	5.88
		Radio	1	5.88
		Booklets	1	5.88
School health officers	1	Books	1	5.88
		Lectures	1	5.88

Table 7.15: Recommended educational media for each of the suggested target groups for the ninth priority health issue (Breast-feeding; n=16).

Suggested Target Group	No	Recommended Educational Media	No	% (n=16)
Mothers/Pregnant mothers	13	TV	9	56.25



		Health professionals	6	37.50
		Booklets/Leaflets	5	31.25
		Home visits	3	18.75
		Radio	2	12.50
		Videos	1	6.25
		Posters	1	6.25
		Mobile educational teams	1	6.25
		Lectures/Seminars	1	6.25
Female youth	6	School curricula	4	25.00
		TV	2	12.50
		Radio	1	6.25
		Youth/Sport clubs	1	6.25
		Booklets/Leaflets	1	6.25
		Lectures/Seminars	1	6.25
		Videos	1	6.25
		Posters	1	6.25
Health services' visitors	4	Health professionals	3	18.75
		Posters	2	12.50
		Videos	2	12.50
		Lectures/Seminars	1	6.25
		Booklets/Leaflets	1	6.25



Women	2	TV	2	12.50
		Radio	2	12.50
		Women societies	1	6.25
Married couples	2	TV	2	12.50
		Booklets/Leaflets	2	12.50
		Radio	1	6.25
		Health services	1	6.25
Youth	2	Booklets/Leaflets	2	12.50
		TV	1	6.25
		Radio	1	6.25
		Newspapers/Magazines	1	6.25
		Cinema/Theatre	1	6.25
		School visits	1	6.25
Post-delivery mothers (in hospitals)	1	Health professionals	1	6.25
		Booklets/Leaflets	1	6.25
All public groups	1	TV	1	6.25
		Newspapers/Magazines	1	6.25



Table 7.16: Recommended educational media for each of the suggested target groups for the tenth priority health issue (Drug Abuse Control; n=14).

Suggested Target Group	No	Recommended Educational Media	No	%age (n=14)
Teenagers/Youth	12	TV	10	71.43
		Lecture/Seminars	8	57.14
		Radio	6	42.86
		Youth/Sport clubs	6	42.86
		Schools/Institutes/Universities	5	35.71
		Booklets/Leaflets	5	35.71
		Mosques	4	28.57
		Youth for youth	2	14.29
		School curricula	2	14.29
		Social workers	2	14.29
		School activities	1	7.14
		Teachers	1	7.14
		Health professionals	1	7.14
		Scouts	1	7.14
		Internet	1	7.14
		Religious leaders	1	7.14
		Confidential tel. line for addicts	1	7.14
Students	8	School curricula	5	35.71



		TV	3	21.43
		School activities	2	14.29
		Teachers	1	7.14
		School visits	1	7.14
		Videos	1	7.14
		Lectures/Seminars	1	7.14
		Posters	1	7.14
		Booklets/Leaflets	1	7.14
		Scouts	1	7.14
		Summer camps	1	7.14
All public groups	6	TV	4	28.57
		Radio	4	28.57
		Mosques	4	28.57
		Booklets/Leaflets	1	7.14
		Social meetings/Gathering places	1	7.14
		Policemen	1	7.14
Parents/Patrons	5	TV	5	35.71
		Radio	4	28.57
		Booklets/Leaflets	3	21.43
		Mosques	3	21.43
		Posters	2	14.29



		Social workers	1	7.14
Teachers	2	Lectures/Seminars	1	7.14
		Newspapers/Magazines	1	7.14
		Booklets/Leaflets	1	7.14
Policemen	2	Booklets/Leaflets	2	14.29
		Mobile educational teams	1	7.14
Youth/N.G.Os' members	1	TV	1	7.14
		Radio	1	7.14
		Lectures/Seminars	1	7.14
		Youth/Sport clubs	1	7.14
Prisoners/Prison guards	1	Lectures/Seminars	1	7.14
		Booklets/Leaflets	1	7.14
Smokers	1	TV	1	7.14
		Mosques	1	7.14
		Books	1	7.14
Addicts	1	Social workers	1	7.14
		Mosques	1	7.14



		Lectures/Seminars	1	7.14
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Table 7.17: Recommended educational media for each of the suggested target groups for the eleventh priority health issue (Smoking Prevention; n=12).

Suggested Target Group	No	Recommended Educational Media	No	% (n=12)
Youth	11	TV	9	75.00
		Youth/Sport clubs	9	75.00
		Radio	6	50.00
		Booklets/Leaflets	6	50.00
		Lectures/Seminars	3	25.00
		Internet	1	8.33
		Cinema/Theatre	1	8.33
		Posters	1	8.33
		N.G.Os	1	8.33
		Scouts	1	8.33
School children/Students	11	School curricula	7	58.33
		TV	7	58.33
		Lectures/Seminars	3	25.00
		Booklets/Leaflets	2	16.67
		School activities	1	8.33
		Radio	1	8.33
		Posters	1	8.33



		Videos	1	8.33
		Teachers	1	8.33
		Role models	1	8.33
		Scouts	1	8.33
		Family	1	8.33
All public groups	6	TV	5	41.67
		Radio	4	33.33
		Booklets/Leaflets	3	25.00
		Mosques	2	16.67
		Health professionals	1	8.33
		Work places	1	8.33
		Lectures/Seminars	1	8.33
		Newspapers/Magazines	1	8.33
		Cinema/Theatre	1	8.33
		Posters	1	8.33
Smokers	6	TV	6	50.00
		Radio	5	41.67
		Lectures/Seminars	4	33.33
		Mosques	2	16.67
		Booklets/Leaflets	1	8.33
		Newspapers/Magazines	1	8.33



		Posters	1	8.33
		N.G.Os	1	8.33
Parents/Patrons	2	TV	2	16.67
		Radio	1	8.33
		Mosques	1	8.33
		Booklets/Leaflets	1	8.33
		Books	1	8.33
		Newspapers/Magazines	1	8.33
		Patrons school board	1	8.33
Mothers	2	TV	2	16.67
		Radio	2	16.67
		Health services	1	8.33
		Booklets/Leaflets	1	8.33
Teachers	1	Lectures/Seminars	1	8.33
		Booklets/Leaflets	1	8.33

Table 7.18: Recommended educational media for each of the suggested target groups for the twelfth priority health issue (Regular Medical Check-up; n=10).

Suggested Target Group	No	Recommended Educational Media	No	% (n=10)
All public groups	4	TV	3	30.00



		Radio	3	30.00
		Booklets/Leaflets	3	30.00
		Posters	2	20.00
		Mobile educational teams	1	10.00
Aged population/ People over 40	4	TV	3	30.00
		Radio	3	30.00
		Health professionals	2	20.00
		Booklets/Leaflets	2	20.00
		Posters	1	10.00
		Home visits	1	10.00
School children/Students	3	Posters	3	30.00
		School curricula	2	20.00
		Booklets/Leaflets	2	20.00
		TV	2	20.00
		Radio	1	10.00
		Teachers	1	10.00
		School activities	1	10.00
		Health professionals	1	10.00
		Family	1	10.00
Parents/Patrons	2	TV	2	20.00



		Radio	2	20.00
		Health professionals	1	10.00
		Newspapers/Magazines	1	10.00
		Lectures/Seminars	1	10.00
Mothers	2	TV	2	20.00
		Radio	2	20.00
		Health professionals	1	10.00
		Health services	1	10.00
		Home visits	1	10.00
		Mobile educational teams	1	10.00
Patients with chronic diseases	2	TV	2	20.00
		Radio	2	20.00
		Booklets/Leaflets	2	20.00
		Posters	1	10.00
Industry labour	2	TV	2	20.00
		Radio	2	20.00
		Posters	2	20.00
		Lectures/Seminars	2	20.00
		Booklets/Leaflets	1	10.00



Workers/Handicraftsmen & related at risk groups	1	Health professionals	1	10.00
		TV	1	10.00
		Radio	1	10.00
		Lectures/Seminars at work places	1	10.00
Youth	1	TV	1	10.00
		Radio	1	10.00
		Lectures/Seminars	1	10.00
Smokers	1	TV	1	10.00
		Radio	1	10.00
		Newspapers/Magazines	1	10.00
		Posters	1	10.00
		Lectures/Seminars	1	10.00
		Youth/Sport clubs	1	10.00
Families of disease history	1	Home visits	1	10.00

Table 7.19: Recommended educational media for each of the suggested target groups for the thirteenth priority health issue (Safe Use of Medications; n=9).

Suggested Target Group	No	Recommended Educational Media	No	% (n=9)
All public groups	8	TV	7	77.78



		Radio	7	77.78
		Booklets/Leaflets	3	33.33
		Lectures/Seminars	2	22.22
		Posters	2	22.22
		Workplaces	2	22.22
		Health professionals	1	11.11
		Mobile educational teams	1	11.11
		Mosques	1	11.11
Youth	4	TV	3	33.33
		Radio	2	22.22
		Lectures	2	22.22
		Youth/Sport clubs	1	11.11
		School curricula	1	11.11
		Booklets/Leaflets	1	11.11
		Youth for youth	1	11.11
		Cinema/Theatre	1	11.11
Parents/Patrons	3	TV	3	33.33
		Radio	3	33.33
		Health professionals	2	22.22
		Newspapers/Magazines	2	22.22
		Posters	1	11.11



Health services'/ Pharmacies' visitors	3	Health professionals	2	22.22
		Posters	2	22.22
		Lectures	1	11.11
School children	2	School curricula	2	22.22
		School activities	1	11.11
		N.G.Os	1	11.11
Mothers	2	Lectures/Seminars	2	22.22
		TV	1	11.11
		Radio	1	11.11
		N.G.Os	1	11.11
		Health services	1	11.11
Aged population	1	Health professionals	1	11.11
Patients with chronic diseases	1	Health professionals	1	11.11

Table 7.20: Recommended educational media for each of the suggested target groups for the equal thirteenth priority health issue (Teeth & Oral Health; n=9).

Suggested Target Group	No	Recommended Educational Media	No	% (n=9)
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Students/School children	8	TV	6	66.67
		School curricula	4	44.44
		Teachers	2	22.22
		Parents	2	22.22
		Posters	2	22.22
		School activities	1	11.11
		Radio	1	11.11
		Booklets/leaflets	1	11.11
		N.G.Os	1	11.11
Mothers	5	TV	4	44.44
		Booklets/Leaflets	4	44.44
		Radio	3	33.33
		Health professionals	2	22.22
		Newspapers/Magazines	1	11.11
		Lectures/Seminars	1	11.11
All public groups	4	TV	3	33.33
		Radio	3	33.33
		Newspapers/Magazines	1	11.11
		Booklets/Leaflets	1	11.11
Youth	4	TV	3	33.33



		Youth/Sport clubs	2	22.22
		Radio	1	11.11
		Health professionals	1	11.11
		Newspapers/Magazines	1	11.11
		Booklets/leaflets	1	11.11
		Health services	1	11.11
Parent/Patrons	2	TV	2	22.22
		Radio	1	11.11
		Posters	1	11.11
		Booklets/Leaflets	1	11.11
Adult generation	1	TV	1	11.11
		Booklets/Leaflets	1	11.11

Table 7.21: Recommended educational media for each of the suggested target groups for the fifteenth priority health issue (Prevention of Cardiovascular Diseases; n=8).

Suggested Target Group	No	Recommended Educational Media	No	% (n=8)
Youth	5	TV	4	50.00
		Booklets/Leaflets	4	50.00
		Radio	3	37.50
		School curricula	3	37.50
		Lectures/Seminars	3	37.50



		Youth/Sport clubs	1	12.50
		Social workers	1	12.50
Aged population/ People over 40	3	TV	3	37.50
		Radio	2	25.00
		Lectures/Seminars	1	12.50
All public groups	2	TV	2	25.00
		Radio	2	25.00
		Booklets/Leaflets	1	12.50
Students	2	School curricula	2	25.00
		School activities	2	25.00
		TV	1	12.50
		Radio	1	12.50
		Booklets/Leaflets	1	12.50
House wives	2	TV	2	25.00
		Radio	2	25.00
		Health professionals	1	12.50
		Women societies	1	12.50
		Booklets/Leaflets	1	12.50



Employees/Officers/ Sedentary professionals	2	Mobile educational teams	2	25.00
		Booklets/Leaflets	2	25.00
		Lectures/Seminars at work places	1	12.50
Adult generation	1	TV	1	12.50
		Health professionals	1	12.50
At risk groups	1	TV	1	12.50
		Radio	1	12.50
		Health professionals	1	12.50

Table 7.22: Recommended educational media for each of the suggested target groups for the sixteenth priority health issue (Prevention of Cancers; n=6).

Suggested Target Group	No	Recommended Educational Media	No	% (n=6)
All public groups	2	TV	2	33.33
		Radio	2	33.33
		Booklets/Leaflets	1	16.67
		Lectures/Seminars	1	16.67
Women	2	Booklets/Leaflets	2	33.33
		Health professionals	1	16.67
		Lectures/Seminars	1	16.67
		Women clubs/gathering	1	16.67



		places		
Youth	2	TV	1	16.67
		Health professionals	1	16.67
		Books	1	16.67
		Booklets/Leaflets	1	16.67
		Lectures/Seminars	1	16.67
Industry labour	2	Lectures/Seminars	2	33.33
		Booklets/Leaflets	2	33.33
		TV	1	16.67
		Radio	1	16.67
Health services' visitors	1	Health professionals	1	16.67
		Booklets/Leaflets	1	16.67
Mothers	1	TV	1	16.67
		Health professionals	1	16.67
Women societies	1	TV	1	16.67
		Radio	1	16.67
		Newspapers/Magazines	1	16.67



Adult generation	1	TV	1	16.67
		Radio	1	16.67
		Health professionals	1	16.67
		Booklets/Leaflets	1	16.67
Aged population	1	Health professionals	1	16.67
		Social workers	1	16.67
		Mosques	1	16.67
Cancer patients	1	Health professionals	1	16.67
		Social workers	1	16.67
		Lectures/Seminars	1	16.67
		Booklets/Leaflets	1	16.67

Table 7.23: Recommended educational media for each of the suggested target groups for the seventeenth priority health issue (Control of Communicable & Endemic Diseases; n=6).

Suggested Target Group	No	Recommended Educational Media	No	% (n=6)
All public groups	3	TV	2	33.33
		Radio	2	33.33
		Public gathering places	1	16.67
		Health professionals	1	16.67
		Posters	1	16.67
		Booklets/Leaflets	1	16.67



		Newspapers/Magazines	1	16.67
Youth	2	TV	1	16.67
		Radio	1	16.67
		Booklets/Leaflets	1	16.67
		Lectures/seminars	1	16.67
		Youth/Sport clubs	1	16.67
Students	1	Lectures/Seminars	1	16.67
		Cinema/Theatre	1	16.67
Teachers	1	Lectures/seminars	1	16.67
Inhabitants of at risk areas	1	TV	1	16.67
		Radio	1	16.67
		Mobile educational teams	1	16.67

Table 7.24: Recommended educational media for each of the suggested target groups for the eighteenth priority health issue (Sport & Physical Exercise; n=4).

Suggested Target Group	No	Recommended Educational Media	No	% (n=4)
School children	2	School curricula	2	50.00
		School activities	1	25.00
		TV	1	25.00



		Teachers	1	25.00
Diabetics	2	Booklets/Leaflets	2	50.00
		TV	1	25.00
		Newspapers/Magazines	1	25.00
		Lectures/Seminars	1	25.00
All public groups	1	TV	1	25.00
		Radio	1	25.00
Youth	1	Youth/Sport clubs	2	50.00
		TV	1	25.00
		Universities	1	25.00
		Summer camps	1	25.00
		Scouts	1	25.00
		Booklets/Leaflets	1	25.00
Adult generation	1	TV	1	25.00
		Radio	1	25.00
		Health clubs	1	25.00
		Booklets/Leaflets	1	25.00
Mothers	1	TV	1	25.00



		Booklets/Leaflets	1	25.00
Smokers	1	TV	1	25.00
		Radio	1	25.00
		Booklets/Leaflets	1	25.00
		Newspapers/Magazines	1	25.00
		Lectures/Seminars	1	25.00
Aged population	1	TV	1	25.00
		Posters	1	25.00
		Booklets/Leaflets	1	25.00
Employees at work places	1	Mobile educational teams	1	25.00
		Booklets/Leaflets	1	25.00
Military personnel	1	Mobile educational teams	1	25.00
		Booklets/Leaflets	1	25.00

Table 7.25: Recommended educational media for each of the suggested target groups for the equal eighteenth priority health issue (Family Planning; n=4).

Suggested Target Group	No	Recommended Educational Media	No	% (n=4)
Married couples	3	Health services	3	75.00
		Booklets/Leaflets	3	75.00



		TV	1	25.00
		Radio	1	25.00
		Mosques	1	25.00
		Newspapers/Magazines	1	25.00
Youth	2	School curricula	2	50.00
		Books	1	25.00
		Youth/Sport clubs	1	25.00
		Booklets/Leaflets	1	25.00
		TV	1	25.00
		Radio	1	25.00
		School visits	1	25.00
Health services' visitors	1	Health professionals	1	25.00
Mothers	1	TV	1	25.00
		Radio	1	25.00
Men	1	TV	1	25.00



Table 7.26: Recommended educational media for each of the suggested target groups for the equal eighteenth priority health issue (First Aid; n=4).

Suggested Target Group	No	Recommended Educational Media	No	% (n=4)
All public groups	2	TV	2	50.00
		Radio	2	50.00
		Booklets/Leaflets	1	25.00
Youth	2	TV	2	50.00
		Radio	2	50.00
		Booklets/Leaflets	2	50.00
		Schools/Universities	1	25.00
		Scouts	1	25.00
Students	1	Lectures/Seminars	1	25.00
Teachers	1	Lectures/Seminars	1	25.00
Housewives	1	Lectures/Seminars	1	25.00
Public security personnel	1	Lectures/Seminars	1	25.00



Table 7.27: Recommended educational media for each of the suggested target groups for the equal eighteenth priority health issue (Control of Diarrhoeal Diseases; n=4).

Suggested Target Group	No	Recommended Educational Media	No	% (n=4)
Mothers	2	TV	2	50.00
		Booklets	2	50.00
		Radio	1	25.00
		Health professionals	1	25.00
		Health services	1	25.00
		Women gathering places	1	25.00
		Booklets/Leaflets	1	25.00
Parents	1	TV	1	25.00
		Radio	1	25.00
Health services' visitors	1	Health professionals	1	25.00
		Lectures/Seminars	1	25.00
Children	1	TV	1	25.00
		Radio	1	25.00
		Booklets/Leaflets	1	25.00



Table 7.28: Recommended educational media for each of the suggested target groups for the equal eighteenth priority health issue (Prevention of Eye Diseases & Blindness; n=4).

Suggested Target Group	No	Recommended Educational Media	No	% (n=4)
All public groups	3	TV	2	50.00
		Radio	2	50.00
		Booklets/Leaflets	2	50.00
		Mosques	1	25.00
		Lectures/Seminars	1	25.00
Students	2	TV	2	50.00
		School curricula	2	50.00
		Radio	1	25.00
		Health professionals	1	25.00
Industry labour	2	TV	2	50.00
		Occupational health professionals at work places	1	25.00
		Mobile educational teams	1	25.00
		Posters	1	25.00
Aged population	1	TV	1	25.00
		Radio	1	25.00



Diabetics	1	TV	1	25.00
		Radio	1	25.00
		Posters	1	25.00
		Booklets/Leaflets	1	25.00
Inhabitants of rural areas	1	Mobile educational teams	1	25.00

Table 7.29: Recommended educational media for each of the suggested target groups for the twenty-third priority health issue (Diabetes Control; n=3).

Suggested Target Group	No	Recommended Educational Media	No	% (n=3)
All public groups	2	TV	2	66.67
		Radio	2	66.67
		School curricula	1	33.33
		Mosques	1	33.33
Youth	1	TV	1	33.33
		Secondary schools	1	33.33
		Booklets/Leaflets	1	33.33
Adult generation	1	TV	1	33.33
		Health professionals	1	33.33



Table 7.30: Recommended educational media for each of the suggested target groups for the twenty-fourth priority health issue (Occupational Health; n=3).

Suggested Target Group	No	Recommended Educational Media	No	% (n=3)
Industry labour/ Handicraftsmen	3	Lectures/Seminars	3	100.00
		TV	2	66.67
		Radio	2	66.67
		Mobile educational teams	1	33.33
		Posters	1	33.33
		Newspapers/Magazines	1	33.33
		Booklets/Leaflets	1	33.33
Farmers	2	TV	2	66.67
		Radio	2	66.67
		Lectures/Seminars	2	66.67
		Posters	1	33.33
		Newspapers/Magazines	1	33.33
		Booklets/Leaflets	1	33.33



Table 7.31: Recommended educational media for each of the suggested target groups for the twenty-fifth priority health issue (Mental & Psychiatric Health; n=2).

Suggested Target Group	No	Recommended Educational Media	No	%age (n=2)
Youth	2	Lectures/Seminars at youth/sport clubs	2	100.00
		Booklets/Leaflets	2	100.00
		TV	1	50.00
		Radio	1	50.00
		Health professionals	1	50.00
All public groups	1	TV	1	50.00
		Health professionals	1	50.00
Teachers	1	TV	1	50.00
		Booklets/Leaflets	1	50.00
Aged population	1	Health professionals	1	50.00
		Social workers	1	50.00
		Booklets/Leaflets	1	50.00
		Mosques	1	50.00
Sick people	1	Health professionals	1	50.00
		Social workers	1	50.00



Table 7.32: Recommended educational media for each of the suggested target groups for the twenty-sixth priority health issue (Family Health; n=1).

Suggested Target Group	No	Recommended Educational Media	No	% (n=1)
Youth at marriage age	1	TV	1	100.00
		Radio	1	100.00
		Lectures/Seminars	1	100.00
		Health professionals	1	100.00
		Social workers	1	100.00
		Youth/Sport clubs	1	100.00
		Newspapers/Magazines	1	100.00

Table 7.33: Recommended educational media for each of the suggested target groups for the twenty-seventh priority health issue (Perinatal Period Care; n=1).

Suggested Target Group	No	Recommended Educational Media	No	% (n=1)
Mothers	1	TV	1	100.00
		Radio	1	100.00
		Health professionals	1	100.00
Fathers	1	Lectures/Seminars at work places	1	100.00
Grandmothers	1	TV	1	100.00
Youth	1	Lectures/Seminars	1	100.00



Table 7.34: Recommended educational media for each of the suggested target groups for the twenty-eighth priority health issue (Relatives Marriage; n=1).

Suggested Target Group	No	Recommended Educational Media	No	% (n=1)
Youth	1	Lectures/Seminars in schools/universities	1	100.00
		Videos	1	100.00
		Cinema/Theatre	1	100.00
Women societies	1	Lectures/Seminars	1	100.00
		Videos	1	100.00
		Cinema/Theatre	1	100.00

Table 7.35: Recommended educational media for each of the suggested target groups for the twenty-ninth priority health issue (Hepatitis-B Control; n=1).

Suggested Target Group	No	Recommended Educational Media	No	% (n=1)
Students/Youth	1	School curricula	1	100.00
		School activities	1	100.00
		TV	1	100.00
		Radio	1	100.00
		Booklets/Leaflets	1	100.00
		Lectures/Seminars	1	100.00
		Youth/Sport clubs	1	100.00
		Mosques	1	100.00



Parents	1	TV	1	100.00
		Radio	1	100.00
		Posters	1	100.00
		Booklets/Leaflets	1	100.00
		Mosques	1	100.00
N.G.Os	1	TV	1	100.00
		Radio	1	100.00
		Lectures/Seminars	1	100.00
		Youth/Sport clubs	1	100.00
Prisoners/Prison guards	1	Lectures/Leaflets	1	100.00
		Booklets	1	100.00

Table 7.36: Recommended educational media for each of the suggested target groups for the thirtieth priority health issue (Obesity Control; n=1).

Suggested Target Group	No	Recommended Educational Media	No	% (n=1)
Children	1	TV	1	100.00
		Radio	1	100.00
		School curricula	1	100.00
Youth	1	TV	1	100.00
		Radio	1	100.00



		School curricula	1	100.00
		Booklets/Leaflets	1	100.00
Adult generation	1	TV	1	100.00
		Radio	1	100.00
		Booklets/Leaflets	1	100.00

Table 7.37: Recommended educational media for each of the suggested target groups for the thirty-first priority health issue (Stress Control; n=1).

Suggested Target Group	No	Recommended Educational Media	No	%age (n=1)
All public groups	1	TV	1	100.00
		Radio	1	100.00
		Books	1	100.00
		Booklets/Leaflets	1	100.00
		Newspapers/Magazines	1	100.00
Desk employees	1	Books	1	100.00

Table 7.38: Recommended educational media for each of the suggested target groups for the thirty-second priority health issue (Utilisation of Health Services; n=1).

Suggested Target Group	No	Recommended Educational Media	No	% (n=1)
All public groups	1	TV	1	100.00
		Booklets/Leaflets	1	100.00



### 7.2.1.6 Suggestions and recommendations

The suggestions and recommendations written by the participants of the first group, together with the number of participants given each suggestion or recommendation were grouped as per Table 7.39.

	<b>Suggestion/Recommendation</b>	<b>No</b>
1	More moral and financial support for health education programmes	10
2	Collaboration of efforts	1
3	Training and specialisation of health education personnel	10
4	Continuity of health education programmes	6
5	A national general directorate, committee or board including all related sectors, not only the health sector, has to be established.	1
6	Quantified evidence should be provided to health professionals in order to motivate the practising health education	1
7	Activation of N.G.Os participation	1
8	Support of health education programmes to limit medical service expenditure	1
9	Emphasis on health professionals' role	2
10	Job description of health professionals should clearly indicate their role as health educators and promoters	1
11	Training health professionals (orientation & skills courses)	5
12	Provision of all needed facilities for health education programmes	8
13	Improve the quality of educational materials	1
14	Simplification of health messages to reach all	2
15	Focus on school health education with provision of audio-visual materials	2
16	Implementation of the health promoting schools initiative	1
17	Training of teachers and headmasters for an effective school health service and school health education	2
18	Co-ordination with education officials and policy makers for orientation and active participation towards improving the school health service and effective school health education.	3
19	Supporting children competitive activities 'Drawing for health'	1
20	Proper utilisation of TV	1
21	Use of health facts and statistics for conducting effective health education	2
22	Efforts to involve politicians and policy makers for an improved public health education service	2
23	Efforts to involve politicians and policy makers for an improved environmental health situation	2
24	More attention to be paid to food policy planning	1
25	Legislation for improved healthy food and nutrition practice. This includes local production, farming, importation & selling of food products	1
26	Legislation towards effective health education	1
27	Proper implementation of legislation to prevent health jeopardising practices	1
28	More emphasis on TV and radio	2
29	Use of a combination of educational media	1



30	Community participation	2
31	Reissuing the periodical health education magazine	1
32	Concentration on evaluation & research	5
33	Concentration on proper planning	4
34	Concentration on re-planning according to social development	1
35	Support for local health education departments, not only for central authority	1
36	A national fully equipped centre for health education to be established	1
37	Attention to be paid to mobile health education teams	4
38	Provision of rooms in health service venues to conduct group health education	3
39	Provision of educational aids and materials within health services	3
40	Securing provision of services that health education programmes are talking about	1

Table 7.39: Suggestions and recommendations.



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7.2.2 Second Questionnaire (General Public Group)

7.2.2.1 Response rate

Out of the distributed 300 copies, 154 copies of the questionnaire were completed and returned (response rate is 51.3%), as shown in Table 7.40.

No. of targeted people	No. of respondents	Percentage
300	154	51.3

Table 7.40: Number of targeted people, number of respondents, and response rate.

7.2.2.2 Description of participants

Table 7.41 distributes the participants according to their gender, area, level of study and age.

Variable		No. of participants (n=154)	Percentage
Gender	Male	83	54
	Female	71	46
Area	Urban	117	76
	Rural	37	24
Level Of Study	Primary school, equivalent or lower	11	7.1
	Secondary school or equivalent	56	36.4
	BSc., equivalent or higher	87	56.5
Age (years)	20 or less	13	8.4
	21-30	66	42.9
	31-40	42	27.3
	41 or above	33	21.4

Table 7.41: Participants according to their gender, area, level of study and age.



Occupations of participants are shown in Table 7.42.

Occupation	No. of participants	Percentage
University staff member	5	3.25
Teacher	24	15.58
Engineer	5	3.25
Lawyer	5	3.25
Social worker	1	0.65
Physician	7	4.55
Pharmacist	2	1.3
Nurse	2	1.3
Technician	1	0.65
Researcher	4	2.59
Employee	30	19.48
Businessman	14	9.09
Farmer	1	0.65
Student	40	25.97
Recently graduated	6	3.9
Retired	2	1.3
Housewife	5	3.25
Total	154	100

Table 7.42: Participants according to their occupation.

7.2.2.3 Indicated priority health issues by the general public

Rank order of the indicated health issues according to their frequency, within the completed and received copies, is shown by Table 7.43. It also shows the percentage of participants who indicated each health issue, out of the total number of participants.

P.	Health Issues	No. of Participants (n=154)	%
1	Drug Abuse Control	98	63.64
2	Personal Hygiene, Sanitation & Environmental Health	79	51.30
3	AIDS Control	55	35.71
3	Regular Medical Check-up	55	35.71



5	Healthy Food & Proper Nutrition	49	31.82
6	Child Health	48	31.17
7	Safe Use of Medications	42	27.27
8	Sport & Physical Exercise	34	22.08
9	Immunisation	32	20.78
10	Breast-feeding	30	19.48
11	Accident Prevention	26	16.88
12	Family Planning	25	16.23
13	Teeth & Oral Health	18	11.69
13	Mental & Psychotic Health	18	11.69
13	Alcohol Drinking Prevention	18	11.69
16	Maternal Health	17	11.04
16	Child Health During School Age /School Health	17	11.04
18	Smoking Prevention	16	10.39
18	Cancers' Prevention	16	10.39
20	First Aid	11	7.14
20	Occupational Health	11	7.14
22	Prevention of Cardiovascular Diseases	9	5.84
22	Diabetes Control	9	5.84
24	Prevention of Eye Diseases & Blindness	7	4.55
25	Control of Diarrhoeal Diseases	5	3.25
25	Hepatitis-B Control	5	3.25
27	Control of Communicable & Endemic Diseases	4	2.60
28	Tuberculosis Control	2	1.30
29	Obesity Control	1	0.65
29	Prevention of Acute Respiratory Infections	1	0.65
29	Blood Donation	1	0.65
29	Lice Prevention	1	0.65
Total number of indicated health issues =32			

Table 7.43: Rank order of health issues according to their frequency.



Table 7.44 shows a comparison between the ten priority health issues indicated by the male participants with those indicated by the female participants. The table also shows the priority number, frequency and percentage for health issues indicated by one group within the ten priority issues and by the other group out the ten priorities.

P.	Males (n=83)	No	%	P.	Females (n=71)	No	%
1	Drug Abuse Control	50	60.24	1	Drug Abuse Control	48	67.61
2	Personal Hygiene, Sanitation & Environmental Health	45	54.22	2	Personal Hygiene, Sanitation & Environmental Health	34	47.89
3	Regular Medical Check-up	32	38.55	3	Healthy Food & Proper Nutrition	27	38.03
4	AIDS Control	31	37.35	4	AIDS Control	24	33.80
5	Child Health	25	30.12	5	Regular Medical Check-up	23	32.39
6	Healthy Food & Proper Nutrition	22	26.51	5	Child Health	23	32.39
7	Sport & Physical Exercise	20	24.10	5	Safe Use of Medications	23	32.39
8	Safe Use of Medications	19	22.89	8	Immunisation	19	26.76
9	Accident Prevention	18	21.69	9	Breast-feeding	18	25.35
10	Family Planning	15	18.07	10	Sport & Physical Exercise	14	19.72
12	Immunisation	13	15.66	11	Family Planning	10	14.08
14	Breast-feeding	12	14.46	13	Accident Prevention	8	11.27

Table 7.44: Comparison between priority health issues indicated by male participants with those indicated by female participants.



Table 7.45 shows a comparison between the ten priority health issues indicated by urban and rural participants. The table also shows the priority number, frequency and percentage for health issues indicated by one group within the ten priority issues and by the other group out the ten priorities.

<b>P.</b>	<b>Urban (n=117)</b>	<b>No</b>	<b>%</b>	<b>P.</b>	<b>Rural (n=37)</b>	<b>No</b>	<b>%</b>
1	Drug Abuse Control	78	66.67	1	Drug Abuse Control	20	54.05
2	Personal Hygiene, Sanitation & Environmental Health	61	52.14	2	Personal Hygiene, Sanitation & Environmental Health	18	48.65
3	Regular Medical Check-up	46	39.32	2	AIDS Control	18	48.65
4	Healthy Food & Proper Nutrition	42	35.90	4	Child Health	12	32.43
5	Safe Use of Medications	38	32.48	5	Regular Medical Check-up	9	24.32
6	AIDS Control	37	31.62	5	Accident Prevention	9	24.32
7	Child Health	36	30.77	7	Immunisation	8	21.62
8	Sport & Physical Exercise	26	22.22	7	Family Planning	8	21.62
9	Immunisation	24	20.51	7	Sport & Physical Exercise	8	21.62
9	Breast-feeding	24	20.51	7	Smoking Prevention	8	21.62
11	Accident Prevention	17	14.53	11	Healthy Food & Proper Nutrition	7	18.92
11	Family Planning	17	14.53	12	Breast-feeding	6	16.22
19	Smoking Prevention	8	6.84	17	Safe Use of Medications	4	10.81

Table 7.45: Comparison between priority health issues indicated by participants in urban areas with those indicated by participants in rural areas.



7.2.2.4 Suggested target groups by the general public

Suggested target groups for each indicated health issue together with the number of participants and their percentage for each suggested group, over the total number of participants who indicated each particular health issue, are shown in Table 7.46.

Indicated Health Issues	No	Suggested Target Groups	No	%
1- Drug Abuse Control	98	Teenagers/Youth/Students	96	97.96
		School children	58	59.18
		Female youth	30	30.61
		Smokers	26	26.53
		Family	21	21.43
		All public groups	10	10.20
		Parents/Patrons	7	7.14
		Military personnel	6	6.12
		Jobless People	5	5.10
		Addicts	3	3.06
		Industrial labour	2	2.04
		Adult generation	2	2.04
		Women	1	1.02
		Health services visitors	1	1.02
		Policemen	1	1.02



2- Personal Hygiene, Sanitation & Environmental Health	79	Children	55	69.62
		Youth	42	53.16
		All public groups	35	44.30
		Family	21	26.58
		Parents/Patrons	20	25.32
		Mothers/Housewives	10	12.66
		Industry labour	9	11.39
		Health services' visitors	7	8.86
		Smokers	7	8.86
		Environmental health/ Sanitation labour	2	2.53
		Catering labour	2	2.53
		Teachers	1	1.27
		Mosques' imams	1	1.27
3- AIDS Control	55	Youth	51	92.73
		Children	28	50.91
		Female youth	26	47.27
		Parents/Patrons	12	21.82
		Family	9	16.36
		Mothers/Housewives	6	10.91
		Women	6	10.91
		All public groups	6	10.91
		Labourers at work places	4	7.27



		Jobless people	2	3.64
3- Regular Medical  Check-up	55	Children/Students	49	89.09
		Youth	29	52.73
		Workers/Labourers	24	43.64
		Patients of chronic diseases	20	36.36
		Parents/Patrons	17	30.91
		Family	16	29.09
		Mothers/Housewives	12	21.82
		All public groups	12	21.82
		Aged population/Over 45 group	7	12.73
		Smokers	5	9.09
		Military personnel	4	7.27
		Pregnant mothers	2	3.64
		Disabled/Handicapped people	2	3.64
		Families of disease history	1	1.82
5- Healthy food & Proper  Nutrition	49	School children	32	65.31
		Mothers/Housewives	21	42.86
		Youth	19	38.78
		Under 6 children	12	24.49
		All public groups	12	24.49
		Family	11	22.45



		Diabetics/Patients with chronic diseases	9	18.37
		Parents/Patrons	7	14.29
		Aged population	7	14.29
		Health services' visitors	2	4.08
		Patients	2	4.08
		Adult population	2	4.08
		Pregnant mothers	1	2.04
		Farmers	1	2.04
		Catering labour	1	2.04
		Mosques' imams	1	2.04
		Teachers	1	2.04
		Overweight people	1	2.04
6- Child Health	48	Mothers	34	70.83
		School children	28	58.33
		Parents/Patrons	24	50.00
		Health services' visitors	20	41.67
		Under 6 children	15	31.25
		Family	5	10.42
		Youth at marriage age	4	8.33
		Female youth	2	4.17
		All public groups	1	2.08



7- Safe Use of Medications	42	Patients with chronic diseases	18	42.86
		Children	16	38.10
		Mothers/Housewives	14	33.33
		Aged population	12	28.57
		Youth	10	23.81
		All public groups	8	19.05
		Parents/Patrons	7	16.67
		Family	6	14.29
		Illiterate people	4	9.52
		Pharmacy's visitors	4	9.52
		Labourers	3	7.14
		Health services' visitors	2	4.76
		Pregnant mothers	1	2.38
		Smokers	1	2.38
		Low education people	1	2.38
8- Sport & Physical Exercise	34	Youth	26	76.47
		School children	15	44.12
		Women	8	23.53
		All public groups	8	23.53
		Patients with diabetes/ Cardiovascular diseases	7	20.59
		Female youth	7	20.59
		Smokers	3	8.82



		Disabled people	2	5.88
		Sedentary employees	2	5.88
		Parents/Patrons	2	5.88
		Labourers	2	5.88
		Teachers	1	2.94
		Mothers	1	2.94
		Aged population	1	2.94
		Mosques' imams	1	2.94
9- Immunisation	32	School children	19	59.38
		Under 6 children	17	53.13
		Parents/Patrons	15	46.88
		Health services' visitors	10	31.25
		Mothers	9	28.13
		Youth at marriage age	5	15.63
		Out-going travellers	4	12.50
		Family	2	6.25
		Female youth	2	6.25
		Incoming labour	1	3.13
		Pregnant mothers	1	3.13
		All public groups	1	3.13
10- Breast-feeding	30	Mothers	25	83.33



		Health services' visitors	8	26.67
		Parents/Patrons	6	20.00
		Female youth	5	16.67
		Women	5	16.67
		Family	4	13.33
		Husbands	1	3.33
11- Accident Prevention	26	Youth	16	61.54
		Children/Teenagers	16	61.54
		Labourers	11	42.31
		Parents/Patrons	6	23.08
		Vehicles' drivers	4	15.38
		Aged population	2	7.69
		Housewives	1	3.85
12- Family Planning	25	Married couples	19	76.00
		Youth	16	64.00
		Women	6	24.00
		Health services' visitors	2	8.00
		All public groups	2	8.00
		Mosques' imams	1	4.00
13- Teeth & Oral Health	18	School children	14	77.78



		Smokers	10	55.56
		Under 6 children	8	44.44
		Youth	5	27.78
		Family	4	22.22
		Parents/Patrons	4	22.22
		Mothers	2	11.11
		Women	2	11.11
		All public groups	2	11.11
		Aged population	1	5.56
		Adult population	1	5.56
		Health services' visitors	1	5.56
13- Mental & Psychotic Health	18	Youth	13	72.22
		Children	11	61.11
		Disabled & handicapped people	7	38.89
		All public groups	5	27.78
		Aged population	2	11.11
		Parents/Patrons	2	11.11
		Mothers	2	11.11
		Poor people	1	5.56
		Patients with chronic diseases	1	5.56
		Orphanage children	1	5.56
		Health services' visitors	1	5.56



13- Alcohol Drinking Prevention	18	Youth	15	83.33
		All public groups	8	44.44
		School children	2	11.11
		Parents/Patrons	2	11.11
		Smokers	2	11.11
		Alcohol addicts	1	5.56
		Jobless people	1	5.56
		Vehicles' drivers	1	5.56
		Labourers	1	5.56
16- Maternal Health	17	Mothers	15	88.24
		Women	8	47.06
		Female youth	7	41.18
		Health services' visitors	7	41.18
		Husbands	4	23.53
		Family	2	11.76
		Youth	2	11.76
		Pregnant/Nursing mother	1	5.88
		At risk mothers	1	5.88
		Diabetic mothers	1	5.88
16- Child Health During	17	School children	17	100.00



School Age/School Health		Teachers	5	29.41
		Mothers	3	17.65
		Parents	3	17.65
18- Smoking Prevention	16	Youth	15	93.75
		Children	13	81.25
		Smokers	10	62.50
		Female youth	3	18.75
		All public groups	2	12.50
		Parents	1	6.25
		Adult generation	1	6.25
		Aged smokers	1	6.25
18- Cancer Prevention	16	All public groups	10	62.50
		Smokers	8	50.00
		Women	5	31.25
		Youth	3	18.75
		Family	2	12.50
		Female youth	1	6.25
		At risk groups	1	6.25
		Children	1	6.25
		Teachers	1	6.25
		Health services' visitors	1	6.25



		Labourers	1	6.25
20- First Aid	11	Children	7	63.64
		Labourers	5	45.45
		Parents/Patrons	4	36.36
		Family	4	36.36
		Youth	2	18.18
		Health services visitors	1	9.09
		Security personnel	1	9.09
20- Occupational Health	11	Industry/Construction Labourers/handicraftsmen	11	100.00
		Students at vocational Training institutes	1	9.09
22- Prevention of Cardiovascular Diseases	9	Youth	4	44.44
		Aged population	4	44.44
		Smokers	4	44.44
		Family	3	33.33
		All public groups	3	33.33
		Overweight people	2	22.22
		School children	1	11.11
		Parents/Patrons	1	11.11
		Health services' visitors	1	11.11



		Families of disease history	1	11.11
		Business people	1	11.11
		Labourers	1	11.11
		Disabled people	1	11.11
22- Diabetes Control	9	Diabetic patients	7	77.78
		All public groups	3	33.33
		Children	1	11.11
		Parents/Patrons	1	11.11
		Adult generation	1	11.11
		Aged population	1	11.11
		Health services' visitors	1	11.11
		Families of diabetic patients	1	11.11
		Diabetic pregnant mothers	1	11.11
24- Prevention of Eye Diseases & Blindness	7	Children	7	100.00
		All public groups	6	85.71
		Health services' visitors	2	28.57
		Youth	1	14.29
		Parents	1	14.29
		Diabetics	1	14.29
25- Control of Diarrhoeal Diseases	5	Parents/Patrons	3	60.00
		Children	2	40.00



		Under 6 children	2	40.00
		Health services' visitors	1	20.00
25- Hepatitis-B Control	5	Youth	4	80.00
		Children	4	80.00
		Parents/Patrons	2	40.00
		Adult generation	2	40.00
		All public groups	1	20.00
27- Control of Communicable & Endemic Diseases	4	All public groups	4	100.00
28- Tuberculosis Control	2	All public groups	2	100.00
29- Obesity Control	1	Youth	1	100.00
		Women	1	100.00
		Men	1	100.00
29- Prevention of Acute Respiratory Infections	1	School children	1	100.00
		Health services' visitors	1	100.00
		Smokers	1	100.00



29- Blood Donation	1	Youth		100.00
29- Lice Prevention	1	Children	1	100.00
		Parents/Patrons	1	100.00

Table 7.46: Suggested target groups for each health issue.

7.2.2.5 Recommended educational media

Tables 7.47 to 7.69 show the recommended educational media for each of the suggested target groups for each particular health issue, together with the number of participants recommended each of the media, also expressed in percentage who suggested the related health issue. Where less than five participants (3% of the total sample) suggested a target group, their recommended educational media are excluded from the list of results. This is to avoid what is assumed as insignificant long listing of recommended educational media for target groups suggested by less than 3% of the participants. Nevertheless, all suggested target groups for each health issue where already listed, including those indicated by less than 3% of the participants.



Table 7.47: Recommended educational media for each of the suggested target groups for the first priority health issue (Drug Abuse Control; n=98).

<b>Suggested Target Group</b>	<b>No</b>	<b>Recommended Educational Media</b>	<b>No</b>	<b>% (n=98)</b>
Teenagers/Youth/Students	96	TV	62	63.27
		Youth/Sport clubs	50	51.02
		Radio	45	45.92
		Lecture/Seminars	24	24.49
		Posters	23	23.47
		Mosques	22	22.45
		Newspapers/Magazines	22	22.45
		Schools/Institutes/ Universities	19	19.39
		Summer clubs/camps	11	11.22
		Cinema/Theatre	11	11.22
		School curricula	8	8.16
		Internet	7	7.14
		Booklets/Leaflets	6	6.12
		Books	6	6.12
		Social workers	6	6.12
		Health professionals	3	3.06
		Scouts	3	3.06
		Parents	1	1.02
		Mobile educational teams	1	1.02
School children	58	School curricula	40	40.82
		TV	23	23.47
		Teachers	21	21.43
		School activities	12	12.24
		Social workers	10	10.20
		Scouts	9	9.18



		Radio	7	7.14
		Lectures/Seminars	7	7.14
		Summer clubs/camps	6	6.12
		Posters	6	6.12
		Children clubs	5	5.10
		Newspapers/Magazines	3	3.06
		Mosques	2	2.04
		Mobile educational teams	2	2.04
		Booklets/Leaflets	1	1.02
		Video	1	1.02
		Parents/Patrons	1	1.02
		Internet	1	1.02
Female youth	30	TV	14	14.29
		Newspapers/Magazines	14	14.29
		Radio	11	11.22
		Schools/Universities	11	11.22
		Lectures/Seminars	7	7.14
		Posters	4	4.08
		Books	3	3.06
		Family	2	2.04
		Booklets/Leaflets	2	2.04
		School curricula	2	2.04
		Summer clubs/camps	2	2.04
		Internet	2	2.04
		Social workers	2	2.04
		Mobile teams	1	1.02
		Teachers	1	1.02
		Health Professionals	1	1.02
		Scouts	1	1.02



Smokers	26	TV	12	12.24
		Radio	9	9.18
		Posters	8	8.16
		Summer clubs/camps	7	7.14
		Newspapers/Magazines	5	5.10
		Mosques	5	5.10
		Scouts	4	4.08
		Schools/Universities	2	2.04
		Youth/Sport clubs	2	2.04
		Military camps	2	2.04
		Lectures/Seminars	2	2.04
		Health professionals	1	1.02
		Internet	1	1.02
		Social workers	1	1.02
		Mobile educational teams	1	1.02
		School curricula	1	1.02
		Books	1	1.02
		Cafés	1	1.02
Family	21	TV	21	21.43
		Radio	10	10.20
		Newspapers/Magazines	6	6.12
		Home visits	4	4.08
		Social workers	4	4.08
		Booklets/Leaflets	2	2.04
		Posters	2	2.04
				1.02
All public groups	10	TV	7	7.14
		Radio	7	7.14
		Mosques	3	3.06
		Booklets/Leaflets	3	3.06



		Newspapers/Magazines	2	2.04
		Books	2	2.04
		Mobile educational teams	2	2.04
		Internet	1	1.02
		Health professionals	1	1.02
		Social workers	1	1.02
		Policemen	1	1.02
		Lectures/Seminars	1	1.02
Parents/Patrons	7	TV	6	6.12
		Radio	6	6.12
		Newspapers/Magazines	3	3.06
		Home visits	2	2.04
		Social workers	2	2.04
		Lectures/Seminars at work places	2	2.04
		Health professionals	1	1.02
		Books	1	1.02
		Booklets/Leaflets	1	1.02
		Mosques	1	1.02
		Posters	1	1.02
Military personnel	6	Military camps	5	5.10
		TV	1	1.02
		Radio	1	1.02
		Scouts	1	1.02
		Lectures/Seminars	1	1.02
		Posters	1	1.02
		Booklets/Leaflets	1	1.02
Jobless People	5	TV	4	4.08



		Radio	3	3.06
		Posters	3	3.06
		Newspapers/Magazines	3	3.06
		Cinema/Theatre	2	2.04
		Mosques	1	1.02
		Books	1	1.02
		Youth/Sport clubs	1	1.02
		Cafés	1	1.02

Table 7.48: Recommended educational media for each of the suggested target groups for the second priority health issue (Personal hygiene, Sanitation & Environmental Health; n=79).

Suggested Target Group	No	Recommended Educational Media	No	% (n=79)
Children	55	School curricula	37	46.84
		Teachers	23	29.11
		TV	21	26.58
		Social workers	10	12.66
		School activities	9	11.39
		Posters	7	8.86
		Children clubs	6	7.59
		Scouts	6	7.59
		Schools/Nursery schools	5	6.33
		Home visits	4	5.06
		Parents/Patrons	3	3.80
		Radio	2	2.53
		Booklets/Leaflets	2	2.53
		Summers clubs/camps	2	2.53
		Lectures/Seminars	2	2.53
		Newspapers/Magazines	2	2.53
		Mobile educational teams	2	2.53



		Family	1	1.27
		School health professionals	1	1.27
		Health professionals	1	1.27
		Video	1	1.27
Youth	42	Youth/Sport clubs	24	30.38
		TV	16	20.25
		Lectures/Seminars	10	12.66
		Simmer clubs/camps	9	11.39
		Posters	9	11.39
		Radio	8	10.13
		Newspapers/Magazines	7	8.86
		Scouts	6	7.59
		School curricula	5	6.33
		Mosques	5	6.33
		Internet	4	5.06
		Booklets/Leaflets	4	5.06
		Schools/Universities	3	3.80
		Teachers	3	3.80
		Books	2	2.53
		Parents	1	1.27
		Health professionals	1	1.27
		Mobile educational teams	1	1.27
All public groups	35	TV	28	35.44
		Radio	19	24.05
		Newspapers/Magazines	16	20.25
		Posters	14	17.72
		Mosques	10	12.66
		Lectures/symposia	10	12.66



		Booklets/Leaflets	6	7.59
		Youth/Sport clubs	5	6.33
		Summer clubs/camps	4	5.06
		Scouts	3	3.80
		Health professionals	2	2.53
		Cinema/Theatre	2	2.53
		Health services	2	2.53
		Work places	2	2.53
		Books	2	2.53
		Home visits	2	2.53
		Social workers	2	2.53
		Internet	2	2.53
		Teachers	1	1.27
Family	21	TV	17	21.52
		Home visits	7	8.86
		Radio	6	7.59
		Posters	5	6.33
		Summer clubs/camps	3	3.80
		Scouts	2	2.53
		Mobile educational teams	2	2.53
		Newspapers/Magazines	2	2.53
		Booklets/Leaflets	1	1.27
		Cinema/Theatre	1	1.27
Parents/Patrons	20	TV	20	25.32
		Radio	15	18.99
		Newspapers/Magazines	7	8.86
		Booklets/Leaflets	4	5.06
		Posters	5	6.33
		Home visits	2	2.53



		Mobile educational teams	2	2.53
		Lectures/Seminars	1	1.27
		Mosques	1	1.27
		Books	1	1.27
Mothers/Housewives	10	TV	8	10.13
		Radio	5	6.33
		Home visits	4	5.06
		Newspapers/Magazines	4	5.06
		Booklets	2	2.53
		Posters	1	1.27
		Social workers	1	1.27
Industry labour	9	Factories/Work places	7	8.86
		Posters	4	5.06
		TV	2	2.53
		Radio	2	2.53
		Occupational health professionals	2	2.53
				1.27
Health services' visitors	7	Health professionals	5	6.33
		Lectures/Seminars	2	2.53
		Posters	2	2.53
		Booklets/Leaflets	2	2.53
		Internet	1	1.27
Smokers	7	TV	5	6.33
		Radio	4	5.06
		Lectures/Seminars	2	2.53
		Newspapers/Magazines	1	1.27
		Posters	1	1.27



		Booklets/Leaflets	1	1.27
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Table 7.49: Recommended educational media for each of the suggested target groups for the third priority health issue (AIDS Control; n=55).

Suggested Target Group	No	Recommended Educational Media	No	% (n=55)
Youth	51	TV	32	58.18
		Youth/Sport clubs	23	41.82
		Posters	16	29.09
		Mosques	15	27.27
		Radio	12	21.82
		Newspapers/Magazines	12	21.82
		Schools/Universities	10	18.18
		Lectures	10	18.18
		Summer clubs	7	12.73
		Booklets/Leaflets	7	12.73
		Internet	7	12.73
		Cinema/Theatre	5	9.09
		Health professionals	5	9.09
		Teachers	2	3.64
		Scouts/Red crescent members	2	3.64
		Mobile educational teams	2	3.64
		Books	1	1.82
		Cafés	1	1.82
Children	28	School curricula	14	25.45
		TV	13	23.64
		School activities	11	20.00
		Teachers	4	7.27
		Posters	5	9.09



		Lectures/Seminars	3	5.45
		Summer clubs/camps	2	3.64
		Mosques	2	3.64
		Mobile educational teams	2	3.64
		Scouts/Red crescent members	2	3.64
		Radio	2	3.64
		Family	1	1.82
		Home visits	1	1.82
		Booklets/Leaflets	1	1.82
Female youth	26	TV	19	34.55
		Newspapers/Magazines	16	29.09
		Posters	7	12.73
		Lectures/Seminars	6	10.91
		Schools/Universities	6	10.91
		Summer clubs/camps	4	7.27
		Books	4	7.27
		Radio	4	7.27
		Sport/youth clubs	3	5.45
		Health professionals	2	3.64
		Booklets/Leaflets	2	3.64
		Social workers	2	3.64
		Internet	1	1.82
Parents/Patrons	12	TV	10	18.18
		Newspapers/Magazines	8	14.55
		Lectures/Seminars	5	9.09
		Social workers	4	7.27
		Posters	3	5.45
		Radio	2	3.64



		Mosques	1	1.82
		Health professionals	1	1.82
		Home visits	1	1.82
		Summer clubs/camps	1	1.82
Family	9	TV	7	12.73
		Home visits	4	7.27
		Mobile educational teams	3	5.45
		Radio	3	5.45
		Newspapers/Magazines	2	3.64
		Health professionals	2	3.64
		Mosques	1	1.82
		Booklets/Leaflets	1	1.82
		Social workers	1	1.82
Mothers/Housewives	6	TV	5	9.09
		Newspapers/Magazines	4	7.27
		Lectures/Seminars	3	5.45
		Radio	2	3.64
		Books	2	3.64
		Booklets/Leaflets	1	1.82
		Mobile educational teams	1	1.82
Women	6	TV	5	9.09
		Radio	4	7.27
		Internet	1	1.82
		Posters	1	1.82
		Home visits	1	1.82
		Booklets/Leaflets	1	1.82
		Health clubs	1	1.82
		Scouts/Red crescent	1	1.82



		members		
		Newspapers/Leaflets	1	1.82
All public groups	6	TV	4	7.27
		Booklets/Leaflets	3	5.45
		Radio	2	3.64
		Health professionals	2	3.64
		Posters	2	3.64
		Newspapers/Magazines	2	3.64
		Sport/Youth clubs	2	3.64
		Summer clubs/camps	1	1.82
		Scouts/Red crescent members	1	1.82
		Books	1	1.82
		Home visits	1	1.82

Table 7.50: Recommended educational media for each of the suggested target groups for the equal third priority health issue (Regular Medical Check-up; n=55).

Suggested Target Group	No	Recommended Educational Media	No	% (n=55)
Children/Students	49	TV	23	41.82
		School curricula	12	21.82
		Teachers	11	20.00
		Nursery schools/ Preparatory schools	9	16.36
		Mobile educational teams	8	14.55
		Social workers	8	14.55
		Health professionals	6	10.91
		Scouts/Red crescent members	5	9.09
		Home visits	5	9.09



		School activities	4	7.27
		Radio	3	5.45
		Parents/Patrons	2	3.64
		Video	2	3.64
		Lectures/Seminars	2	3.64
		Booklets/Leaflets	2	3.64
		Summer clubs/camps	2	3.64
		Posters	1	1.82
		Children clubs	1	1.82
		Newspapers/Magazines	1	1.82
Youth	29	Youth/Sport clubs	17	30.91
		TV	13	23.64
		Summer clubs/camps	7	12.73
		Lectures/Seminars	6	10.91
		Scouts/Red crescent members	6	10.91
		Schools/Universities	5	9.09
		Mosques	5	9.09
		Cinema/Theatre	5	9.09
		Newspapers/Magazines	4	7.27
		Posters	3	5.45
		Books	2	3.64
		Radio	2	3.64
		Internet	2	3.64
		Mobile educational teams	2	3.64
		School curricula	1	1.82
		Health professionals	1	1.82
		Booklets/Leaflets	1	1.82
Workers/Labourers	24	Lectures/Seminars	10	18.18



		Posters	10	18.18
		TV	7	12.73
		Work places	6	10.91
		Booklets/Leaflets	5	9.09
		Radio	4	7.27
		Occupational health professionals	4	7.27
		Newspapers/Magazines	3	5.45
		Mobile educational teams	2	3.64
		Social workers	1	1.82
		Video	1	1.82
		Health services	1	1.82
Patients with chronic diseases	20	TV	9	16.36
		Health professionals	8	14.55
		Booklets/Leaflets	8	14.55
		Home visits	7	12.73
		Mobile educational teams	4	7.27
		Lectures/Seminars	2	3.64
		Posters	2	3.64
		Radio	2	3.64
		Scouts/Red crescent members	1	1.82
		Newspapers/Magazines	1	1.82
		Social workers	1	1.82
Parents/Patrons	17	TV	13	23.64
		Radio	9	16.36
		Booklets/Leaflets	5	9.09
		Posters	5	9.09
		Newspapers/Magazines	5	9.09



		Lectures/Seminars	3	5.45
		Books	2	3.64
		Home visits	2	3.64
		Health professionals	1	1.82
		Summer clubs/camps	1	1.82
		Mobile educational teams	1	1.82
Family	16	TV	15	27.27
		Radio	8	14.55
		Booklets/Leaflets	5	9.09
		Newspapers/Magazines	3	5.45
		Home visits	3	5.45
		Lectures/Seminars	2	3.64
		Posters	2	3.64
		Health professionals	2	3.64
		Health services	2	3.64
		Mobile educational teams	1	1.82
Mothers/Housewives	12	TV	7	12.73
		Home visits	5	9.09
		Radio	4	7.27
		Booklets/Leaflets	4	7.27
		Posters	3	5.45
		Newspapers/Magazines	3	5.45
		Summer clubs/camps	2	3.64
		Social workers	2	3.64
All public groups	12	TV	10	18.18
		Radio	6	10.91
		Posters	5	9.09
		Newspapers/Magazines	5	9.09



		Health professionals	5	9.09
		Mosques	3	5.45
		Lectures/Seminars	3	5.45
		Mobile educational teams	2	3.64
		Booklets/Leaflets	2	3.64
		Summer clubs/camps	2	3.64
		Internet	1	1.82
		Scouts/Red crescent members	1	1.82
		Work places	1	1.82
Aged population/ Over 45 group	7	TV	5	9.09
		Radio	3	5.45
		Home visits	3	5.45
		Mosques	3	5.45
		Newspapers	2	3.64
		Mobile educational teams	2	3.64
		Health professionals	1	1.82
		Posters	1	1.82
Smokers	5	TV	4	7.27
		Newspapers/Magazines	2	3.64
		Radio	1	1.82
		Mosques	1	1.82
		Sport/Youth clubs	1	1.82
		Books	1	1.82
		Lectures/Seminars	1	1.82
		Health professionals	1	1.82
		Posters	1	1.82



Table 7.51: Recommended educational media for each of the suggested target groups for the fifth priority health issue (Healthy Food & Proper Nutrition; n=49).

Suggested Target Group	No	Recommended Educational Media	No	% (n=49)
School children	32	School curricula	26	53.06
		TV	14	28.57
		Teachers	12	24.49
		Scouts/Red crescent members	7	14.29
		School activities	6	12.24
		Newspapers/Magazines	4	8.16
		Family	3	6.12
		Posters	3	6.12
		Radio	3	6.12
		Summer clubs/camps	2	4.08
		Booklets/Leaflets	1	2.04
		Health professionals	1	2.04
		Mobile educational teams	1	2.04
		Health services	1	2.04
Mothers/Housewives	21	TV	16	32.65
		Radio	11	22.45
		Home visits	8	16.33
		Newspapers/Magazines	4	8.16
		Mobile educational teams	4	8.16
		Health professionals	3	6.12
		Social workers	3	6.12
		Booklets/Leaflets	3	6.12
		Posters	2	4.08
		School curricula	1	2.04
		Sons & daughters	1	2.04



		Books	1	2.04
		Lectures/Seminars	1	2.04
Youth	19	Youth/Sport clubs	17	34.69
		TV	10	20.41
		Radio	6	12.24
		Lectures/Seminars	6	12.24
		Booklets/Leaflets	5	10.20
		Scouts/Red crescent members	2	4.08
		Mobile educational teams	2	4.08
		Newspapers/Magazines	1	2.04
		Posters	1	2.04
Under 6 children	12	Nursery schools	10	20.41
		TV	4	8.16
		Home visits	3	6.12
		Family	2	4.08
		Health services	2	4.08
		Posters	1	2.04
		Radio	1	2.04
		Health professionals	1	2.04
		Newspapers/Magazines	1	2.04
All public groups	12	TV	10	20.41
		Radio	6	12.24
		Posters	5	10.20
		Health professionals	4	8.16
		Newspapers/Magazines	4	8.16
		Mosques	3	6.12
		Booklets/Leaflets	3	6.12



		Lectures/Seminars	3	6.12
		Home visits	2	4.08
		Health services	2	4.08
		Scouts/Red crescent members	1	2.04
		Social workers	1	2.04
		Internet	1	2.04
Family	11	TV	11	22.45
		Radio	8	16.33
		Home visits	5	10.20
		Booklets/Leaflets	2	4.08
		Health professionals	2	4.08
		Lectures/Seminars	1	2.04
Diabetics/Patients with chronic diseases	9	Health professionals	5	10.20
		TV	4	8.16
		Newspapers/Magazines	3	6.12
		Posters	2	4.08
		Mosques	2	4.08
		Radio	1	2.04
		Booklets	1	2.04
		Cinema/Theatre	1	2.04
Parents/Patrons	7	TV	7	14.29
		Radio	4	8.16
		Posters	1	2.04
		Newspapers/Magazines	1	2.04
Aged population	7	Health professionals	6	12.24



		TV	4	8.16
		Family	2	4.08
		Radio	1	2.04
		Scouts/Red crescent members	1	2.04
		Mosques	1	2.04

Table 7.52: Recommended educational media for each of the suggested target groups for the sixth priority health issue (Child Health; n=48).

Suggested Target Group	No	Recommended Educational Media	No	% (n=48)
Mothers	34	TV	23	47.92
		Radio	15	31.25
		Home visits	9	18.75
		Health professionals	6	12.50
		Posters	5	10.42
		Newspapers/Magazines	4	8.33
		Booklets/Leaflets	4	8.33
		Lectures	3	6.25
		Mobile educational teams	2	4.17
		Social workers	1	2.08
School children	28	School curricula	17	35.42
		Teachers	11	22.92
		School activities	9	18.75
		TV	9	18.75
		Booklets/Leaflets	5	10.42
		Social workers	5	10.42
		Scouts/Red crescent members	4	8.33
		School health	4	8.33



		professionals		
		Books	3	6.25
		Posters	3	6.25
		Newspapers/Magazines	2	4.17
		Home visits	2	4.17
		Mobile educational teams	2	4.17
		Video	1	2.08
		Health professionals	1	2.08
		Family	1	2.08
		Summer clubs	1	2.08
Parents/Patrons	24	TV	21	43.75
		Radio	13	27.08
		Newspapers/Magazines	10	20.83
		Home visits	10	20.83
		Posters	7	14.58
		Books	4	8.33
		Booklets/Leaflets	4	8.33
		Mobile educational teams	3	6.25
		Lectures/Seminars	2	4.17
		Mosques	2	4.17
		Summer clubs/camps	1	2.08
		Social workers	1	2.08
Health services' visitors	20	Health professionals	14	29.17
		Booklets/Leaflets	9	18.75
		Posters	8	16.67
		Lectures/Seminars	7	14.58
		Social workers	3	6.25
		Books	1	2.08



Under 6 children	15	Nursery schools	12	25.00
		TV	5	10.42
		Home visits	5	10.42
		Radio	3	6.25
		Governess/Social workers	3	6.25
		Posters	2	4.17
		Scouts/Red crescent members	1	2.08
		Mobile educational teams	1	2.08
Family	5	Health professionals	2	4.17
		Home visits	2	4.17
		TV	1	2.08
		Radio	1	2.08
		Books	1	2.08
		Lectures	1	2.08
		Summer clubs/camps	1	2.08
		Newspapers/Magazines	1	2.08
		Scouts/Red crescent members	1	2.08
		Cinema/Theatre	1	2.08

Table 7.53: Recommended educational media for each of the suggested target groups for the seventh priority health issue (Safe Use of Medications; n=42).

Suggested Target Group	No	Recommended Educational Media	No	% (n=42)
Patients with chronic Diseases	18	TV	12	28.57
		Health professionals	9	21.43
		Posters	7	16.67
		Booklets/Leaflets	6	14.29



		Radio	5	11.90
		Newspapers/Magazines	5	11.90
		Mobile educational teams	4	9.52
		Lectures/Seminars	2	4.76
		Written advice on the prescription	2	4.76
		Social workers	1	2.38
		Scouts/Red crescent members	1	2.38
Children	16	School curricula	10	23.81
		School activities	6	14.29
		Teachers	6	14.29
		TV	6	14.29
		Social Workers	3	7.14
		Parents/Patrons	2	4.76
		Nursery Schools	2	4.76
		Posters	2	4.76
		Summer clubs/camps	2	4.76
		Newspapers/Magazines	1	2.38
		Home visits	1	2.38
		Video	1	2.38
		Cinema/Theatre	1	2.38
		Internet	1	2.38
Mothers/Housewives	14	TV	11	26.19
		Radio	6	14.29
		Health professionals	5	11.90
		Newspapers/Magazines	5	11.90
		Home visits	3	7.14
		Booklets	2	4.76



		Posters	1	2.38
		Lectures/Seminars	1	2.38
		Sons & daughters	1	2.38
Aged population	12	TV	6	14.29
		Radio	4	9.52
		Health professionals	4	9.52
		Mobile educational teams	4	9.52
		Home visits	3	7.14
		Booklets/Leaflets	3	7.14
		Family	2	4.76
		Social workers	2	4.76
		Newspapers/Magazines	2	4.76
		Stickers on medications packets	1	2.38
		Mosques	1	2.38
		Posters	1	2.38
Youth	10	Youth/Sport clubs	4	9.52
		Summer clubs/camps	4	9.52
		Lectures/Seminars	4	9.52
		TV	3	7.14
		School curricula	3	7.14
		Newspapers/Magazines	3	7.14
		Radio	2	4.76
		Booklets/Leaflets	2	4.76
		Posters	2	4.76
		School activities	1	2.38
		Books	1	2.38
		Cinema/Theatre	1	2.38



All public groups	8	TV	5	11.90
		Lectures/Seminars	4	9.52
		Newspapers/Magazines	4	9.52
		Health professionals	3	7.14
		Radio	3	7.14
		Posters	3	7.14
		Sport/Youth clubs	1	2.38
		Summer clubs/camps	1	2.38
Parents/Patrons	7	TV	6	14.29
		Radio	2	4.76
		Newspapers/Magazines	2	4.76
		Health professionals	1	2.38
		Booklets/Leaflets	1	2.38
		Summer clubs/camps	1	2.38
		Home visits	1	2.38
		Posters	1	2.38
		Mobile educational teams	1	2.38
Family	6	TV	6	14.29
		Radio	4	9.52
		Newspapers/Magazines	3	7.14
		Health professionals	1	2.38
		Posters	1	2.38
		Booklets/Leaflets	1	2.38
		Mobile educational teams	1	2.38
		Summer clubs/camps	1	2.38



Table 7.54: Recommended educational media for each of the suggested target groups for the eighth priority health issue (Sport & Physical Exercise; n=34).

Suggested Target Group	No	Recommended Educational Media	No	% (n=34)
Youth	26	Youth/Sport clubs	20	58.82
		TV	10	29.41
		Newspapers/Magazines	6	17.65
		Lectures/Seminars	5	14.71
		Summer clubs/camps	4	11.76
		Schools/Universities	4	11.76
		Radio	3	8.82
		Scouts/Red crescent members	3	8.82
		School activities	2	5.88
		Booklets/Leaflets	2	5.88
		Cinema/Theatre	2	5.88
		Teachers	1	2.94
		Books	1	2.94
		Health professionals	1	2.94
School children	15	School activities	8	23.53
		TV	6	17.65
		Children clubs	6	17.65
		School curricula	5	14.71
		Scouts/Red crescent members	3	8.82
		Teachers	3	8.82
		Radio	3	8.82
		Summer clubs/camps	3	8.82
		School visits	2	5.88
		Cinema/Theatre	1	2.94



		Family	1	2.94
		Home visits	1	2.94
		Booklets/Leaflets	1	2.94
Women	8	TV	8	23.53
		Newspapers/Magazines	5	14.71
		Radio	3	8.82
		Books	2	5.88
		Home visits	2	5.88
		Booklets/Leaflets	1	2.94
All public groups	8	TV	6	17.65
		Radio	3	8.82
		Newspapers/Magazines	3	8.82
		Posters	3	8.82
		Lectures/Seminars	2	5.88
		Workplaces	2	5.88
		Booklets/Leaflets	1	2.94
		Books	1	2.94
Patients with diabetes/ cardiovascular diseases	7	Health professionals	6	17.65
		TV	4	11.76
		Home visits	2	5.88
		Radio	1	2.94
		Mobile educational teams	1	2.94
		Social workers	1	2.94
		Booklets/Leaflets	1	2.94
		Newspapers/Magazines	1	2.94
Female youth	7	School activities	3	8.82
		Summer clubs/camps	3	8.82



		Youth/Sport clubs	2	5.88
		TV	2	5.88
		Schools/Universities	1	2.94
		Radio	1	2.94
		Newspapers/Magazines	1	2.94

Table 7.55: Recommended educational media for each of the suggested target groups for the ninth priority health issue (Immunisation; n=32).

Suggested Target Group	No	Recommended Educational Media	No	% (n=32)
School children	19	School curricula	13	40.63
		TV	10	31.25
		Mobile educational teams	5	15.63
		School activities	4	12.50
		Scouts/Red crescent members	4	12.50
		Teachers	3	9.38
		Parents/Patrons	2	6.25
		Lectures/Seminars	2	6.25
		Social workers	2	6.25
		Health professionals	2	6.25
		Video	1	3.13
		Home visits	1	3.13
		Newspapers/Magazines	1	3.13
		Health services	1	3.13
Under 6 children	17	TV	8	25.00
		Nursery schools	8	25.00
		Home visits	4	12.50
		Posters	3	9.38
		Health professionals	2	6.25



		Social workers	2	6.25
		Cinema/Theatre	2	6.25
		Scouts/Red crescent members	1	3.13
		Mobile educational teams	1	3.13
		Health services	1	3.13
Parents/Patrons	15	TV	11	34.38
		Radio	9	28.13
		Posters	6	18.75
		Home visits	5	15.63
		Booklets/Leaflets	5	15.63
		Newspapers/Magazines	4	12.50
		Lectures/Seminars	4	12.50
		Mobile educational teams	3	9.38
		Health professionals	1	3.13
		Mosques	1	3.13
Health services' visitors	10	Booklets/Leaflets	8	25.00
		Health professionals	7	21.88
		Posters	5	15.63
		Lectures/Seminars	2	6.25
		Books	1	3.13
Mothers	9	TV	8	25.00
		Radio	7	21.88
		Posters	3	9.38
		Newspapers/Magazines	3	9.38
		Mobile educational teams	2	6.25
		Home visits	1	3.13
		Booklets/Leaflets	1	3.13



		Social workers	1	3.13
Youth at marriage age	5	TV	4	12.50
		Youth/Sport clubs	3	9.38
		Health professionals	2	6.25
		Radio	1	3.13
		Booklets/Leaflets	1	3.13
		Newspapers/Magazines	1	3.13

Table 7.56: Recommended educational media for each of the suggested target groups for the tenth priority health issue (Breast-feeding; n=30).

Suggested Target Group	No	Recommended Educational Media	No	% (n=30)
Mothers	25	TV	24	80.00
		Radio	21	70.00
		Health professionals	10	33.33
		Newspapers/Magazines	7	23.33
		Posters	4	13.33
		Home visits	3	10.00
		Booklets/Leaflets	3	10.00
		Books	3	10.00
		Social workers	2	6.67
		Lectures/Seminars	2	6.67
		Mobile educational teams	2	6.67
		Books	1	3.33
Health services' visitors	8	Health professionals	7	23.33
		Lectures/Seminars	3	10.00
		Booklets/Leaflets	2	6.67
		Social workers	1	3.33
		Video	1	3.33



Parents/Patrons	6	TV	5	16.67
		Radio	3	10.00
		Newspapers	3	10.00
		Booklets/Leaflets	2	6.67
		Posters	2	6.67
		Home visits	2	6.67
Female youth	5	TV	4	13.33
		Lectures/Seminars	4	13.33
		Radio	3	10.00
		Schools/Universities	3	10.00
		School curricula	2	6.67
		Posters	1	3.33
		Newspapers	1	3.33
Women	5	TV	4	13.33
		Radio	3	10.00
		Newspapers/Magazines	2	6.67
		Health professionals	1	3.33

Table 7.57: Recommended educational media for each of the suggested target groups for the eleventh priority health issue (Accident Prevention; n=26).

Suggested Target Group	No	Recommended Educational Media	No	% (n=26)
Youth	16	TV	14	53.85
		Radio	8	30.77
		Youth/Sport clubs	8	30.77
		Newspapers/Magazines	7	26.92
		Schools/Universities	7	26.92
		Lectures/Seminars	5	19.23



		Cinema/Theatre	5	19.23
		Mosques	3	11.54
		Posters	3	11.54
		Internet	2	7.69
		Scouts/Red crescent members	2	7.69
		Family	1	3.85
		Summer clubs/camps	1	3.85
		Booklets/Leaflets	1	3.85
		Books	1	3.85
		Teachers	1	3.85
		Posters	1	3.85
Children/Teenagers	16	School curricula	9	34.62
		TV	7	26.92
		Teachers	6	23.08
		Posters	3	11.54
		Scouts/Red crescent members	3	11.54
		Cinema/Theatre	3	11.54
		Lectures/Seminars	2	7.69
		Booklets/Leaflets	1	3.85
		Newspapers/Magazines	1	3.85
		Radio	1	3.85
		Family	1	3.85
		Parents/Patrons	1	3.85
		Social workers	1	3.85
Labourers	11	Posters	7	26.92
		TV	5	19.23
		Occupational health	4	15.38



		Professionals		
		Radio	3	11.54
		Booklets/Leaflets	3	11.54
		Newspapers/Magazines	1	3.85
Parents/Patrons	6	TV	6	23.08
		Newspapers/Magazines	5	19.23
		Radio	3	11.54
		Posters	3	11.54
		Teachers	1	3.85
		Lectures/Seminars	1	3.85
		Social workers	1	3.85

Table 7.58: Recommended educational media for each of the suggested target groups for the twelfth priority health issue (Family Planning; n=25).

Suggested Target Group	No	Recommended Educational Media	No	% (n=25)
Married couples	19	TV	18	72.00
		Radio	14	56.00
		Newspapers	8	32.00
		Health services	4	16.00
		Lectures/Seminars	3	12.00
		Social workers	3	12.00
		Mosques	3	12.00
		Books	3	12.00
		Health professionals	2	8.00
		Posters	2	8.00
		Booklets/Leaflets	1	4.00
Youth	16	TV	8	32.00
		Lectures	8	32.00



		Radio	6	24.00
		Youth/Sport clubs	6	24.00
		Schools/Universities	4	16.00
		Newspapers/Magazines	4	16.00
		Books	3	12.00
		Booklets/Leaflets	2	8.00
		Posters	2	8.00
		Scouts/Red crescent members	2	8.00
		Social workers	2	8.00
		Cinema/Theatre	2	8.00
		Health professionals	1	4.00
		Mosques	1	4.00
		Internet	1	4.00
Women	6	TV	6	24.00
		Radio	6	24.00
		Lectures/Seminars	3	12.00
		Posters	1	4.00
		Mobile educational teams	1	4.00
		Newspapers/Magazines	1	4.00

Table 7.59: Recommended educational media for each of the suggested target groups for the thirteenth priority health issue (Teeth & Oral Health; n=18).

Suggested Target Group	No	Recommended Educational Media	No	% (n=18)
School children	14	School curricula	13	72.22
		TV	10	55.56
		Teachers	6	33.33
		School activities	3	16.67
		Radio	2	11.11



		Posters	2	11.11
		Parents/Patrons	2	11.11
		Health professionals	1	5.56
Smokers	10	TV	9	50.00
		Newspapers/Magazines	6	33.33
		Radio	4	22.22
		Booklets/Leaflets	4	22.22
		Posters	4	22.22
		Lectures/Seminars	3	16.67
		Health professionals	2	11.11
		Books	2	11.11
		Mosques	1	5.56
		Internet	1	5.56
		Stickers on the cigarettes' Packets	1	5.56
Under 6 children	8	Nursery schools	6	33.33
		TV	5	27.78
		Children clubs	4	22.22
		Posters	2	11.11
		Parents/Patrons	1	5.56
		Scouts/Red crescent members	1	5.56
Youth	5	Youth/Sport clubs	3	16.67
		TV	2	11.11
		Newspapers/Magazines	2	11.11
		Booklets/Leaflets	2	11.11
		Health services	1	5.56
		Schools/Universities	1	5.56



		Books	1	5.56
		Summer clubs/camps	1	5.56
		Lectures/Seminars	1	5.56
		Posters	1	5.56

Table 7.60: Recommended educational media for each of the suggested target groups for the equal thirteenth priority health issue (Mental & Psychotic Health; n=18).

Suggested Target Group	No	Recommended Educational Media	No	% (n=18)
Youth	13	TV	8	44.44
		Radio	7	38.89
		Youth/Sport clubs	6	33.33
		Mosques	5	27.78
		Newspapers/Magazines	4	22.22
		Schools/Universities	3	16.67
		Social workers	3	16.67
		Summer clubs/camps	2	11.11
		Posters	2	11.11
		Cinema/Theatre	2	11.11
		School curricula	1	5.56
		Books	1	5.56
		Health professionals	1	5.56
		Internet	1	5.56
Children	11	Social workers	8	44.44
		Teachers	5	27.78
		School curricula	4	22.22
		School activities	4	22.22
		Health professionals	3	16.67
		Nursery schools	3	16.67
		Family	1	5.56



		Parents	1	5.56
Disabled & handicapped people	7	Social workers	5	27.78
		Mobile educational teams	4	22.22
		TV	3	16.67
		Radio	2	11.11
		Health professionals	1	5.56
		Family	1	5.56
		Scouts/Red crescent members	1	5.56
		Newspapers/Magazines	1	5.56
		Mosques	1	5.56
		Lectures/Seminars	1	5.56
		Home visits	1	5.56
All public groups	5	Newspapers/Magazines	4	22.22
		TV	3	16.67
		Radio	3	16.67
		Social workers	2	11.11
		Lectures/Seminars	2	11.11
		Health professionals	1	5.56
		Posters	1	5.56

Table 7.61: Recommended educational media for each of the suggested target groups for the equal thirteenth priority health issue (Alcohol Drinking Control; n=18).

Suggested Target Group	No	Recommended Educational Media	No	% (n=18)
Youth	15	Youth/Sport clubs	9	50.00
		TV	9	50.00



		Newspapers/Magazines	7	38.89
		Radio	6	33.33
		Mosques	6	33.33
		Posters	2	11.11
		School curricula	1	5.56
		Teachers	1	5.56
		Internet	1	5.56
		Lectures/Seminars	1	5.56
		Family	1	5.56
		Scouts/Red crescent members	1	5.56
		Booklets/Leaflets	1	5.56
		Military personnel	1	5.56
All public groups	8	Newspapers/Magazines	5	27.78
		TV	4	22.22
		Radio	4	22.22
		Mosques	3	16.67
		Posters	3	16.67
		Youth/Sport clubs	2	11.11
		Health professionals	2	11.11
		Booklets/Leaflets	1	5.56
		Mobile educational teams	1	5.56
		Summer clubs/camps	1	5.56
		Lectures/Seminars	1	5.56
		Military camps	1	5.56



Table 7.62: Recommended educational media for each of the suggested target groups for the sixteenth priority health issue (Maternal Health; n=17).

Suggested Target Group	No	Recommended Educational Media	No	% (n=17)
Mothers	15	TV	14	82.35
		Radio	13	76.47
		Newspapers/Magazines	7	41.18
		Home visits	5	29.41
		Posters	3	17.65
		Health professionals	2	11.76
		Lectures	1	5.88
		Mobile educational teams	1	5.88
		Social workers	1	5.88
		Books	1	5.88
Women	8	TV	6	35.29
		Newspapers/Magazines	4	23.53
		Radio	3	17.65
		Home visits	3	17.65
		Health professionals	1	5.88
		Books	1	5.88
Female youth	7	TV	5	29.41
		Radio	4	23.53
		School curricula	3	17.65
		Books	3	17.65
		Newspapers/Magazines	3	17.65
		Schools/Universities	2	11.76
		Health professionals	1	5.88
		Social workers	1	5.88
		Booklets/Leaflets	1	5.88



		Summers clubs/camps	1	5.88
		Lectures/Seminars	1	5.88
Health services' visitors	7	Posters	5	29.41
		Booklets	4	23.53
		Lectures/Seminars	3	17.65
		Health professionals	2	11.76
		Newspapers/Magazines	1	5.88
		Books	1	5.88

Table 7.63: Recommended educational media for each of the suggested target groups for the equal sixteenth priority health issue (Child Health During School Age/School Health; n=17).

Suggested Target Group	No	Recommended Educational Media	No	% (n=17)
School children	17	School curricula	10	58.82
		TV	9	52.94
		Radio	6	35.29
		School activities	5	29.41
		Posters	4	23.53
		Scouts/Red crescent members	4	23.53
		Teachers	3	17.65
		Social workers	3	17.65
		School health professionals	2	11.76
		Mobile educational teams	2	11.76
		Health professionals	2	11.76
		Booklets/Leaflets	1	5.88
		Summer clubs/camps	1	5.88
		Books	1	5.88



Teachers	5	TV	4	23.53
		Radio	2	11.76
		Booklets/Leaflets	2	11.76
		Lectures/Seminars	2	11.76
		Newspapers/Magazines	2	11.76

Table 7.64: Recommended educational media for each of the suggested target groups for the eighteenth priority health issue (Smoking Prevention; n=16).

Suggested Target Group	No	Recommended Educational Media	No	% (n=16)
Youth	15	TV	10	62.50
		Youth/Sport clubs	8	50.00
		Lectures/Seminars	6	37.50
		Radio	5	31.25
		Newspapers/Magazines	5	31.25
		Booklets/Leaflets	3	18.75
		Internet	2	12.50
		Summer clubs/camps	1	6.25
		Books	1	6.25
		Posters	1	6.25
		Schools/Universities	1	6.25
		Mosques	1	6.25
		Social workers	1	6.25
		Cinema/Theatre	1	6.25
Children	13	School curricula	9	56.25
		TV	8	50.00
		Teachers	7	43.75
		Scouts/Red crescent members	3	18.75
		Posters	3	18.75



		Parents/Patrons	1	6.25
		Lectures/Seminars	1	6.25
		Mosques	1	6.25
		Family	1	6.25
		School activities	1	6.25
		Newspapers/Magazines	1	6.25
Smokers	10	TV	8	50.00
		Mosques	8	50.00
		Radio	6	37.50
		Health professionals	4	25.00
		Booklets/Leaflets	2	12.50
		Newspapers/Magazines	2	12.50
		Scouts/Red crescent members	1	6.25
		Social workers	1	6.25
		Lectures/Seminars	1	6.25
		Books	1	6.25

Table 7.65: Recommended educational media for each of the suggested target groups for the equal eighteenth priority health issue (Cancers' Prevention; n=16).

Suggested Target Group	No	Recommended Educational Media	No	% (n=16)
All public groups	10	TV	9	56.25
		Radio	6	37.50
		Booklets/Leaflets	5	31.25
		Newspapers/Magazines	4	25.00
		Lectures/Seminars	3	18.75
		Posters	2	12.50
		Health professionals	1	6.25
		Home visits	1	6.25



Smokers	8	TV	6	37.50
		Radio	3	18.75
		Newspapers/Magazines	3	18.75
		Booklets/Leaflets	2	12.50
		Health professionals	1	6.25
		Posters	1	6.25
Women	5	Health professionals	4	25.00
		TV	2	12.50
		Newspapers/Magazines	2	12.50
		Booklets/Leaflets	1	6.25
		Books	1	6.25
		Women gathering places	1	6.25

Table 7.66: Recommended educational media for each of the suggested target groups for the twentieth priority health issue (First Aid; n=11).

Suggested Target Group	No	Recommended Educational Media	No	% (n=11)
Children	7	School curricula	6	54.55
		Teachers	3	27.27
		TV	2	18.18
		Posters	2	18.18
		School activities	2	18.18
		Scouts/Red crescent members	2	18.18
		Lectures/Seminars	1	9.09
		Children clubs	1	9.09
Labourers	5	Lectures at work places	4	36.36
		Posters	4	36.36



		TV	1	9.09
		Occupational health Professionals	1	9.09
		Booklets/Leaflets	1	9.09

Table 7.67: Recommended educational media for each of the suggested target groups for the equal twentieth priority health issue (Occupational Health; n=11).

Suggested Target Group	No	Recommended Educational Media	No	% (n=11)
Industry/Construction Labourers/Handicraftsmen	11	Occupational health professionals	8	72.73
		Factories/Work places	7	63.64
		Posters	7	63.64
		TV	6	54.55
		Booklets/Leaflets	4	36.36
		Lectures/Seminars	4	36.36
		Radio	2	18.18

Table 7.68: Recommended educational media for each of the suggested target groups for the equal twenty-second priority health issue (Diabetes Control; n=9).

Suggested Target Group	No	Recommended Educational Media	No	% (n=9)
Diabetic patients	7	TV	5	55.56
		Radio	3	33.33
		Lectures/Seminars	3	33.33
		Health professionals	1	11.11
		Health services	1	11.11
		Booklets/Leaflets	1	11.11
		Newspapers/Magazines	1	11.11



Table 7.69: Recommended educational media for each of the suggested target groups for the twenty-fourth priority health issue (Prevention of Eye Diseases & Blindness; n=7).

Suggested Target Group	No	Recommended Educational Media	No	% (n=7)
Children	7	School curricula	7	100.00
		TV	3	42.86
		Radio	2	28.57
		Teachers	2	28.57
		Health professionals	2	28.57
		Posters	1	14.29
All public groups	6	Health professionals	4	57.14
		TV	3	42.86
		Radio	2	28.57
		Newspapers/Magazines	2	28.57
		Lectures/Seminars	2	28.57
		Books	2	28.57
		Mobile educational teams	1	14.29
		Booklets/Leaflets	1	14.29
		Home visits	1	14.29
		Summer clubs/camps	1	14.29

#### 7.2.2.6 Suggestions and recommendations:

The suggestions and recommendations written by the participants were grouped and shown in Table 7.70, together with the number of participants who made each suggestion or recommendation.

	Suggestion/Recommendation	No
1	More moral and financial support for health education programmes	4
2	Collaboration of efforts	
3	Training and specialisation of health education personnel	5
	Continuity of health education programmes	5
4	Emphasising on the role of health professionals	1



5	Training health professionals	1
6	Providing all required facilities for health education programmes	4
7	Increasing frequency of broadcasting TV programmes	2
8	Increasing space for health education within broadcast and printed media	1
9	Improving the quality of educational materials	1
10	Using art in designing printed materials	1
11	Simplifying health messages to reach all	3
12	Focusing on school health	4
13	Focusing on home visits	5
14	Focusing on booklets and leaflets	1
15	Focusing on books, newspapers and magazines	1
16	More emphasis on TV	17
17	More emphasis on radio	6
18	Broadcasting TV programmes instead of noisy TV spots	1
19	Using a combination of educational media	3
20	Directing health education to all public groups	1
21	Paying more attention to child education	1
22	Paying more attention on educating youth by lectures	1
23	Utilising youth clubs	1
24	Using youth leisure or spare time	1
25	Paying more attention to educating students by means of lectures	1
26	Paying more attention to school health education	13
27	Training of teachers to conduct successful school health education	2
28	Focusing on parents and family education in order to educate children	1
29	Activating social workers role	1
30	Reissuing the periodical health education magazine	1
31	Supporting face to face health education, not just broadcast media.	1
32	Preparing entertainment broadcasts with health advise	1
33	Concentrating on evaluation	1
34	Organising researches and studies to improve the service	1
35	People are to determine their own health education needs	1
36	Designing the messages according to the targeted groups	1
37	Designing special booklets and leaflets for blind individuals	1
38	Supporting local health education departments/offices with educational materials	2
39	Mobile health education programmes in rural areas	1
40	Health education programmes should not use the approach of instructions e.g. 'Do this and don't do that'	1
41	Securing provision of health services that health education programmes are talking about	1
42	Supporting the health education component within the scouts' activities	4
43	Paying more attention to the importance of the role of health education programmes to inform the public about new diseases and ways of prevention and protection	4
44	Educating people on imported and canned food	1
45	Giving more attention to mobile educational teams to industrial, service, and other work places since they are considered as gathering places	3

Table 7.70: Suggestions and recommendations.



### 7.3 DISCUSSION

The national report, 'Libya: Human Development Report 2000', developed by the National Authority for Documentation and Information (NADI, 2000a) has shown that the major issue in the field of health service in Libya is poor planning techniques. It stressed the need for scientifically based national planning.

The present study is the first one in Libya for assessing future needs and planning health education programmes. It utilised a combination of top-to-down and down-to-top approaches. The study involved key people in the public health service; health planners, policy makers and policy implementers together with a representative sample of the general public. The participation of ex-under secretaries of health for the past 30 years was, with difficulty, secured. They, of course, constituted a part of the officials group.

Within the general public sample, equal participation of both genders has been secured and the percentage of urban to rural participants resembles the one within the Libyan population configuration. Different age groups, levels of study and occupations were represented in the study sample.

The study represents a practical application of the Ottawa Charter for Health Promotion and the Mexico Framework for Countrywide Plans of Action for Health Promotion, calling for community participation in health services' planning. Different countries adopt numerous techniques, approaches, processes and implementation mechanisms in their priority-setting exercises. A similar technique is implemented in many of the countries around the globe. An academic body within the ministry of health with the participation of the general public set the priorities in some countries (The Ministry of Health in Mexico, 2000; WHO, 2000). Likewise, politicians, health professionals and the general public are involved in setting population needs in other countries. In some, national agents, partners, financial and other groups are involved. Donors play a significant role in priority-setting in many countries (WHO, 2000).



One may argue that number of general public sample size in this study (300) or the response rate (51.3%) is low. However, in such qualitative and attitude measuring research using an open-end questionnaire and addressing the general public, operational reasons other than statistical ones make this sample size appropriate and accept the response rate. The approach of open-end questionnaire is close to the interview approach, at which study sample is not necessarily reaches the figure in this study. Despite the need for appropriate education in order to complete the used questionnaire, it is time consuming. Answering the questionnaire needs 20-30 minutes, according to the participant education, understanding and personal skills. Poor interest of the general public participants and unexpected feed-back may have a negative influence on response rate of participants. This is different in the case of health officials at which 86.7% responded. This can largely be attributed to interest of the officials in the study objectives and to expected feed-back of obtained findings which are needed for future planning and organisation of health services in the country.

### **7.3.1 Indicated Priority Health Issues**

The ten priority health issues, indicated by the health officials, for future health education in Libya are: Personal Hygiene, Sanitation & Environmental Health; Immunisation; Healthy Food & Proper Nutrition; Child Health; Maternal Health; AIDS Control; Accident Prevention; Child Health During School Age/School Health; Breast-feeding; and Drug Abuse Control. This order is set as per their frequency, which shows their order of priority.

Setting these issues as a priority for future programmes of health education is largely dependent on the awareness of the officials drawn from their training and experience. International and national epidemiological data play an important role to influence officials' opinions. It represents a response to Libya's demographic, social and epidemiological situation as well as life-style practices.

Widely used health situation indicators in the world, including infant, child and maternal mortality rates, morbidity rates, percentage of infants of low birth weight and life expectancy at birth, are significantly influenced by a number of



issues. They include the improved personal hygiene, sanitation & environmental health; immunisation against major infectious diseases; maternal and child health, including family planning and breast-feeding; and healthy food & proper nutrition. Extraordinary gains in health improvement in Libya over the past three decades, with reference to the above mentioned indicators (LSMCH, 1997; NADI, 2000a; GSHSW, 2000a) can be considered as a priority worth sustaining.

Essential components of primary health care stated by the Ama Ata Declaration (WHO-UNICEF, 1978) and the basic elements of primary health care in Libya, identified by the National Strategy Providing Health for All and by All (The General Secretariat, 1995), which need general public awareness and behaviour change, are all included within the priority issues indicated by the health officials participating at this study. Provision of essential drugs and appropriate treatment of common diseases and injuries are issues perceived to require policy and service organisational actions, more than general public health education action.

Table 7.71 presents the eight components of primary health care stated in Alma Ata (1978), and Table 7.72 shows the eleven elements of primary health care identified in Libya (1995).

No	Components of Primary Health Care (Alma Ata Declaration)
1	Education Concerning Prevailing Health Problems and the Methods for Preventing & Controlling Them
2	Promotion of Food Supply & Proper Nutrition
3	Adequate Supply of Safe Water & Basic Sanitation
4	Maternal & Child Health Care, including Family Planning
5	Immunisation Against Major Infectious Diseases
6	Prevention & Control of Locally Endemic Diseases
7	Appropriate Treatment of Common Diseases & Injuries
8	Provision of Essential Drugs

Table 7.71: Components of Primary Health Care in Alma Ata Declaration.



No.	Basic Elements of Primary Health Care in Libya
1	Health and Social Education & Information
2	Healthy Food & Proper Nutrition
3	Safe Water Supply, Sanitation & Environmental Health
4	Maternal & Child Health care and Family Planning
5	Immunisation
6	Control of Communicable and Non-communicable Diseases
7	First Aid & Appropriate Treatment of Common Diseases & Injuries
8	Provision of Essential Drugs
9	Psychiatric Health
10	Occupational Health
11	Health & Social Care of Elderly People

Table 7.72: Basic Elements of Primary Health Care in Libya.

The ‘Libya: Human Development Report’ (NADI, 2000a) pointed out that there is a number of factors contributing to morbidity in Libya. They include air pollution in the main cities; water pollution with salts in some areas of the country; and overuse of insecticides in agriculture.

HIV/AIDS Control, Accident Prevention, Drug Abuse Control and other new era life-style related health issues are considered of high importance as well. They have become an increasingly public health concern with significant health and economic, as well as social and family consequences.

According to WHO (1999a), more than 33 million people, throughout the world, are victims of HIV or AIDS. In the year 1998, for example, AIDS killed 2.5 million people. It is now the number one killer in sub-Saharan Africa, which is close to Libya. Within the Libyan community, similar to the other more conservative societies in the Islamic world, in which sexual activity between unmarried couples is not a norm, the HIV/AIDS spread continues to be on a lower



level than in other regions (WHO, 1999a). This tacitly assumes that sexual intercourse is the main cause of virus transmission.

However, the extraordinary high fatality and modes of HIV transmission and associated behavioural patterns raised questions about the adequacy of defences against the disease. With the absence of treatment or cure in sight, the disease continues to spread across the political borders between states at an alarming rate. With no immediate hope of a vaccine, the need for public health policies and programmes to protect the communities from the virus spread has focused attention on the role of education as a powerful medium for control.

WHO has advocated the role of education in HIV/AIDS prevention (Gezairy, 1994; WHO, 1999a & b). The globally identified need for designing effective health education programmes to protect the individuals and communities from HIV/AIDS, together with the concern which resulted from Benghazi-outbreak, encouraged the health officials to identify AIDS control as the sixth priority issue within future health education planning. In Benghazi Paediatric Hospital, more than 370 cases of HIV infection among children were detected in 1998 (GSHSW, 1999). It has been reported that the cumulative AIDS cases in Libya, until 1998, are 1552, and shown that 913 of them are not Libyans. Total cases in 1998 alone were 491. Most of the non-Libyan cases are from the sub-Saharan region (GSHSW, 2000a).

Health officials put Accident Prevention at the same priority level as AIDS Control. This could be largely based on the alarming national reports. For example, the national report, Libya: The Human Development Report 2000, (NADI, 2000a) has stated that Libya is one of the leading countries in the world with respect to rates of death due to traffic accidents. In 1999, there were 200 traffic accidents per 100 000 people. Annual deaths due to traffic accidents in the years 1997-1999 is about 24.5 per 100 000 of population, compared with 14 in the Scandinavian countries and 23 in the Eastern European states. The report showed that, in 1999, 43.4% of the accident cases led to severe injuries, and 12% led to death. 57% of total deaths and 65% of total injuries occurred in the age group of 15-34 years. Within one of the Libyan provinces, Zawia, 11% of deaths were due



to accidents. According to the same report, there were 13.2 work accidents per 100 000 people of industrial power in 1997. More than 5% of industrial manpower had industrial injuries. 1.8% out of these cases led to death.

Drug abuse is recently becoming an issue that needs an immediate action in the country. It has been regarded by the health officials as one of the ten priority issues within future health education programmes. Drug abuse in Libya is illegal by law, prohibited by religion and socially unacceptable. Although, the reporting systems of drug abusers in the country are not always reliable (Khshaiba, 2000). According to the General Secretariat of Health and Social Welfare Report on Narcotics and Psychotropics (GSHSW, 2000b), the estimated number of people afflicted in 1998 is thought to be 7000. Based on the shared experience of the author and Dr. Khshaiba, the Head of Department of Narcotics and Psychotropics at the General Secretariat of Health and Social Welfare (2000), this number has to be three to four fold greater in the present year, 2000. It is deemed that the epidemic continues to spread at a higher rate. According to the General Secretariat of Health and Social Welfare (2000b), the high-risk group is mostly aged between twenties and thirties. Addiction is higher in single abusers compared with married ones. These are mainly male, but the incidence of females is increasing progressively. Drug abuse is largely connected with HIV transmission, as a result of shared use of needles. Khshaiba (2000) advocated the use of religion, sports, media, the school system and universities for substance abuse prevention.

Other health issues including; Smoking Prevention; Regular Medical Check-up; Safe Use of Medications; Teeth & Oral Health; and Prevention of Cardiovascular Diseases, were considered by the officials at the eleventh, the twelfth, the thirteenth, the equal thirteenth, and the fifteenth priority issues respectively.

The general public ranked the ten priority health issues as follows: Drug Abuse Control; Personal Hygiene, Sanitation & Environmental Health; AIDS Control; Regular Medical Check-up; Healthy Food & Proper Nutrition; Child Health; Safe Use of Medications; Sport & Physical Exercise; Immunisation; and



Breast-feeding. The next five priority health issues are: Accident Prevention; Family Planning; Teeth & Oral Health; Mental & Psychiatric Health; and Alcohol Drinking Control.

Within the general public group, male assessment of future priorities is similar to that of the females. Minor differences were found when urban participants' setting is compared with rural.

Table 7.73 shows a comparison between the ten priority health issues indicated by the health officials with those indicated by the general public. The table, also, shows the priority number, frequency and percentage where health issues indicated by one group within the ten priority issues and by the other group out of the ten priorities.

The general public agrees with the health officials in selecting the same seven health issues within the ten priority issues. Three health issues were set by the officials within the ten priorities, while the general public accorded them at a slightly lower priority. Maternal Health is considered by the officials to be the equal fourth priority issue and held by the general public at the sixteenth priority issue. The officials assess School Health to have the sixth priority among the health issues, while the general public perceive it to have the equal sixteenth priority. Accident Prevention held by the officials as equal sixth priority and by the general public as equal sixteenth.

Concurrence between the officials and the general public in this study as regards future priority health issues differs from the appropriate research hypothesis.

One of the general public participants was in favour of setting maternal health and school health at a relatively lower priority. He referred to the success gained in the fields of school health and maternal health services and relatively high public awareness over the past years leading to improvement in the existing situation. This could be a reasonable explanation. The same applies to immunisation programme.



P.	Officials Group (n=52)	No	%	P.	General Public Group (n=154)	No	%
1	Personal Hygiene, Sanitation & Environmental Health	29	55.77	1	Drug Abuse Control	98	63.64
2	Immunisation	23	44.23	2	Personal Hygiene, Sanitation & Environmental Health	79	51.30
3	Healthy Food & Proper Nutrition	20	38.46	3	AIDS Control	55	35.71
4	Child Health	19	36.54	3	Regular Medical Check-up	55	35.71
4	Maternal Health	19	36.54	5	Healthy Food & Proper Nutrition	49	31.82
6	AIDS Control	17	32.69	6	Child Health	48	31.17
6	Accident Prevention	17	32.69	7	Safe Use of Medications	42	27.27
6	Child Health During School Age/School Health	17	32.69	8	Sport & Physical Exercise	34	22.08
9	Breast-feeding	16	30.77	9	Immunisation	32	20.78
10	Drug Abuse Control	14	26.92	10	Breast-feeding	30	19.48
12	Regular Medical Check-up	10	19.23	11	Accident Prevention	26	16.88
13	Safe Use of Medications	9	17.31	16	Maternal Health	17	11.04
18	Sport & Physical Exercise	4	7.69	16	Child Health During School Age/School Health	17	11.04

Table 7.73: Comparison between priority health issues indicated by officials' participants with those indicated by the general public participants.



On the other hand, the general public indicated the issues of Regular Medical Check-up; Safe Use of Medications; and Sport & Physical Exercise to have the equal third, the seventh and the eighth priorities respectively, however, the officials ranked them twelfth, thirteenth and eighteenth respectively.

Drug Abuse Control has been perceived by the general public as an issue of top priority, with no competition. Nevertheless, the officials ranked it tenth. This could be because officials think scientifically, while the general public does not. The magnitude of the problem might be seen by the officials as not that serious when compared with AIDS, for example, but still they consider it to be one of the priority ten issues, in which 27% of them identified it as one of the five priorities.

A comment was pointed out by a number of the participants from both groups, with which the author agrees, has to be indicated in this discussion. Health issues of lower frequency can be considered as not of high priority, but not ignored. Moreover, most of health issues overlap, being interrelated and integrated. An example of this includes; Maternal Health, Family Planning, Breast-feeding, Child Health, School Health, Immunisation, Control of Diarrhoeal Diseases, ... and others. Another example includes; Smoking Prevention, Drug Abuse Control, AIDS Control and Hepatitis-B Control.

Although the indicated more than 30 priority issues cannot all be priorities for everybody at the same time, they constitute an aid in decision-making about priorities and to monitoring progress.

In the 52<sup>nd</sup> World Health Assembly, 1999, the ministers of health of WHO member states, in a ministerial round table, discussed the priority setting in the health sector (WHO, 2000). They mentioned that, in nearly all countries, the demand for health care outstripped available resources. It is not easy to satisfy the competing priorities of different individuals and groups. Thus, each country has to make hard decisions about priorities, which must be reflected in both the allocation of resources and the achievement of equitable health outcomes.



Most of the priority health issues identified in this study were included by the National Plan for Health Education. The plan was prepared by a group of four members of the National Committee for Health and Social Education, including two ex-under secretaries of health and the author (Abdelhadi et al., 1997). Plan issues include: Maternal Health; Child Health; Immunisation; Breast-feeding; Personal Hygiene & Sanitation; Environmental Health; Healthy Food & Proper Nutrition; Diarrhoeal Diseases Prevention; Teeth & Oral Health; Smoking, Drug Abuse & Alcohol Drinking Control; AIDS & Sexually Transmitted Diseases Control; Accidents Prevention including Home & Drowning Accidents; Scorpions Control; Sport & Physical Exercise; Prevention of Cardiovascular, Safe Use of Medications; Diabetes Control; Prevention of Acute Respiratory Diseases; and Visual Health.

The study hypothesis accord with the obtained results in considering AIDS Control and Drug Abuse Control as of the priority areas to be addressed by future health education programmes in Libya.

Over the past decades, research has clearly indicated that many health problems can be traced to modifiable life-style factors or environmental factors (Michael, 1982). Early health promotion interventions focused primarily on skills training programmes to change the behaviour of individuals that put them at risk (Meyer et al., 1980). As well, the importance of involving family and friends in encouraging the individual to sustain behaviour change efforts has been recognised (Moriskey et al., 1985).

Hertzlinger and Calkins (1986) criticised risk reduction programmes, on the basis that they tend to be single-component, top-down designs and known to be least effective for long-term behaviour changes.

Ronald Labonte, the famous Canadian community health educator, commented on life-styles approach to health promotion when he said: "While the life-styles approach to health promotion has undeniably scored some successes and found a place in our popular culture, its limitations are also becoming increasingly evident. Poverty, underemployment and pollution are playing a



growing role in the health problems of our society, and we are coming to recognise that neither life-styles nor the modern epidemic of chronic diseases can be viewed in isolation from our social, economic, industrial and political structures” (Labonte, 1987).

Health promotion strategies have recently gone beyond interventions for high-risk groups to community-wide intervention strategies (Bloom, 1968). Community-based health promotion works through community structures such as schools, work and leisure settings, and neighbourhood organisations to promote healthy life-styles and environments.

Thus, the community-based approach emphasises the importance of the social context in health promotion. Moreover, it emphasises a philosophy of empowerment in which individuals, groups, and organisations actively participate in changing community settings and developing community norms towards the goals of enhanced health and well-being (McKnight, 1985; Rappaport, 1987).

In her message in the World Health Report (1999d), the WHO Director-General highlighted some key priorities as they are defined in the Proposed Budget 2000-2001. They include:

- Reduction of the burden of sickness and suffering resulting from communicable diseases, with an emphasis on malaria, HIV/AIDS, tuberculosis and completing eradication of poliomyelitis.
- Dealing with the rising toll of non-communicable diseases, with a special attention to cancer and cardiovascular diseases through the Tobacco Free Initiative.
- Delivery of high-quality care for children, adolescents and women.
- Making progress on the issues of population and reproductive health, with a special focus on maternal mortality and adolescent sexual and reproductive health.
- Supporting immunisation programmes.
- Reduction of the enormous burden of malnutrition, especially in children.
- Improving mental health.



WHO member states, in general, favour public health and primary health care. However, health priorities vary widely among states. Setting priorities largely depends on states' specific characteristics and indicators.

In many parts of the world, pneumonia, diarrhoea, malaria, measles and malnutrition are still the main killers. In the countries where health promotion concepts and ideologies have been primarily developed, the priority health issues are the so called life-style diseases, sexually transmitted diseases, environmental health hazards and mental health problems (Rajala, 1995).

In the Eastern Mediterranean Region, to which Libya belongs, Dr. Gro Harlem indicated at the opening ceremony of the 46<sup>th</sup> Meeting of the Eastern Mediterranean Regional Committee, in Cairo, 1999 (WHO, 1999c) that reduction of mortality and morbidity rates is to be obtained by:

- promoting vaccination programmes towards total polio eradication;
- conducting health education to control HIV/AIDS;
- supporting programmes fighting tuberculosis;
- continuing work against malaria;
- improving maternal health;
- amelioration of reproductive health;
- cancer prevention;
- control of cardiovascular diseases;
- improving mental health; and
- tobacco control.

Dr. Gezairi, WHO Regional Director of the Eastern Mediterranean, pointed in his address at the same meeting that health issues and related problems are many. However, he stressed two issues; the first one is the smoking issue and the second is polio eradication.

The top health priority in the United Arab Emirates, in the past years, has been the immunisation programme. In Norway, the first priority is given to mental



health. Maternal and child health is the priority health issue in Croatia, Gabon, Cote d'Ivoire and Mali. In many other countries, such as Jordan, Lao and Jamaica, primary health care, with its eight components, is held to be the priority. In Burkina Faso, the first priority is the control over the definition of priorities (WHO, 2000).

The Ministry of Health in Mexico (2000) outlined 12 substantive programmes for disease prevention and control within the health promotion strategy in the country. They are: Reproductive Health; Child Health; Adult & Elderly Health; Diseases Transmitted by Vectors, Zoonosis, Mycobacteriosis & Cholera; Epidemiological Emergencies & Disasters; HIV/Aids & Sexually Transmitted Diseases; Substance Abuse; Cervical Cancer; and Dental Health

The British government focuses on five key areas for change up to and beyond the year 2000: heart disease and stroke, cancer, mental illness, sexual health, and accidents (DOH, 1992). It also identifies four 'risk factors' or target areas where strategies for change should be focused, namely: smoking, diet and nutrition, blood pressure, and sexual behaviour (Vernon, 1996).

'The Health for All Australians Report' (1988) represented the first national attempt in Australia to compile goals and targets for improving health and reducing inequalities in health status among population groups. Twenty goals and 65 targets were grouped into three major categories: population groups, major cases of sickness and death, and risk factors. The goals and targets were set for major causes of premature death, major risk factors, and causes of premature morbidity in areas in which change had been demonstrated to be feasible. They reflected international experience at the time and were in line with those set by other Western nations.

'The Health for All Australians Report' contained a series of recommendations on priorities for action. Five national priority areas were proposed, namely: improved nutrition, preventable cancers, high blood pressure, injury prevention, and the health of older people.



A new framework for health goals and targets was developed through a process of consultation and included in the final report, 'Goals and Targets for Australia's Health in the Year 2000 and beyond' (Nutbeam, et al., 1993). The key features of goals and targets are: preventable mortality and morbidity; healthy lifestyles and risk factors; health literacy & health skills; and healthy environments.

Diarrhoea, malaria, pneumonia, measles and tuberculoses are known to be among the leading causes of death in Nigeria. The role of Nigerian health educators is to encourage community participation and to work closely with local people so as to plan, implement, and evaluate programmes that will reduce the percentage of those who are not knowledgeable about the causes and symptoms of these diseases (Airhihenbuwa, 1988).

Each area or zone within the individual country can identify particular local needs, in consultation with local people. Country priorities could vary according to the season, as in Bangladesh (WHO, 2000).

### **7.3.2 Suggested Target Groups**

Population groups within any society are numerous. The demographic, social, cultural, economic and health situations of these groups differ. Groups' perceptions and needs are to be distinct and access to these groups has to utilise special techniques to meet with the particular perceptions and needs.

McGuire's analysis of effective communication and persuasion methods suggests that messages that are more closely suited to the values and attitudes of those to whom they are directed will be more effective than other types of messages (McGuire, 1969).

Both of the groups, the officials and the general public, suggested a number of specific groups of the public to be targeted, in addressing each of the different health issues within the future health education programmes.



Within the officials' assessment, on a number of health issues, it is suggested that health education programmes be generalised towards all public groups and at the same time specialised towards specific concerned groups. Generalisation occurred in the issues of Personal Hygiene, Sanitation & Environmental Health; Healthy Food & Proper Nutrition; Regular Medical Check-up; Safe Use of Medications; Prevention of Cancers; Control of Communicable & Endemic Diseases; First Aid; Prevention of Eye Diseases & Blindness; and Diabetes Control.

The general public also recommended the generalisation of health education programmes in the above mentioned areas. However, targeting the young generation in particular is seen by them as more important.

Different terms were chosen, by both groups, to indicate that the young are essential target group, especially for health issues which need a life-style change. Children, teenagers, students and youth were the main suggested groups - according to their frequency- aiming at Drug Abuse Control, AIDS Control, Accident Prevention and Smoking Prevention. This represents an orientation of health education planning on the basis of at-risk groups' approach. These same groups were given top place for a number other issues such as Personal Hygiene, Sanitation & Environmental Health; Healthy Food & Proper Nutrition; Sport and Physical Exercise; and Teeth & Oral Health.

According to Health Education Authority (1991a), the approach of targeting children by long term health education messages has been criticised on the basis that the concept of a long-term health message may not have real meaning for the individual. The notion that there might be a greater chance of being affected by lung cancer when older if they develop smoking habits at an early age is not likely to be considered relevant. Adolescents do not always see the connection between what they do today and what may happen in the future as a result. This is not necessarily valid because youth education about the importance of immunisation in disease prevention may have a future effect on them when they become parents. The same applies to female youth and breast-feeding.



The high proportion of children and youth within the Libyan population largely supports the study participants -the officials and the general public- in focusing on the young generation as a main target group for many of the health issues. It has to be indicated here that only 8.4% of the general public study sample are aged less than 20 years. Table 7.74 illustrates the estimated Libyan population configuration in the year 2000 according to age (NADI, 2000b).

Age group	Number	Percentage
0-4	627 891	12.46
5-9	668 459	13.26
10-14	671 730	13.33
15-19	668 714	13.27
20-24	582 675	11.56
25-29	448 184	8.89
30-34	328 600	6.52
35-39	225 658	4.48
40-44	152 371	3.02
45-49	146 025	2.90
50-54	119 922	2.38
55-59	112 829	2.24
60-64	89 819	1.78
65-69	79 471	1.58
70-74	51 476	1.02
75-79	30 883	0.61
80-84	18 994	0.38
85 & over	15 990	0.32
<b>Total</b>	<b>5 039 691</b>	<b>100.00</b>

Table 7.74: Estimated Libyan population configuration in the year 2000 according to age.

Moreover, youth can be considered as a crucial impact group within the community, and they can be targeted in order to bring about individual and societal change towards better health.

Other important groups suggested include parents/patrons, mothers, fathers, family and teachers. This means that the study participants put emphasis on targeting the new generation by both means; directly and indirectly. Young people face decisions about some particular issues at an early age, and accordingly they need to be empowered to make wise health choices before reaching



adulthood and before adult behaviours are established. In other words, this is life-style orientation at an early stage. It is the formulation or development of healthy personalities who think, decide and practice health.

Female youth, in particular, were identified by both groups, as important in a number of health issues largely related to their gender. This includes AIDS Control, Breast-feeding and Maternal Health. In the first issue, immediate action is required. However, in the other two, female youth often prepared for marriage and healthy maternity. Mothers were seen as a main target in addressing Maternal Health and Breast-feeding.

Parents, patrons, mothers and fathers were considered as important groups of people to be targeted with respect to children's health issues which lie under their control, such as Child Health and Immunisation.

For addressing issues such as Healthy Food & Proper Nutrition and Personal Hygiene, Sanitation & Environmental Health, it is suggested that mothers and housewives be targeted, since they have the main control over these issues.

Both groups recommended targeting health services' visitors when specific health issues are to be addressed or certain groups are to be reached. This is seen in the areas of Child Health; Immunisation; Maternal Health; and Breast-feeding. The approach of patient education can also be utilised at the health care setting in the areas of Safe use of Medications or patients of chronic diseases such as diabetic patients and patients with cardiovascular diseases. Health services are seen the appropriate place to reach *'the hard to reach'* audiences. Examples include children before school age, mothers and housewives.



### 7.3.3 Recommended Health Educational Media

The third component of this part of the study recommends the media or channels of conducting the health education interventions to reach the intended audience concerning each particular health issue. Specific media for reaching specific audiences were suggested.

Both of the participants' groups recommended broadcast mass media as the most important media to be employed within future health education programmes. This is seen with regard to addressing all of health issues and in targeting most of the groups. TV is usually perceived as more potent than radio.

TV was considered in part one of this research, by both the health officials and general public, as the leading medium for mediating health education. The extensive health education programmes and spots disseminated through the Libyan TV channels are perceived as contributing to these findings.

The literature review shows three alternative views propounded about the effectiveness of the mass media in health promotion. The first view demonstrates that mass media are all powerful and have untapped potential. An example supporting this is the reduction in tobacco smoking throughout the Western world following extensive TV campaigns. The second view says that mass media are ineffective. This arose as a reaction to the lack of overwhelmingly positive results from many of the early studies, such as those aimed at encouraging seatbelt use in the USA where the wearing of seatbelts was not legally required. The third view points out that mass media may be effective under some circumstances if the appropriate conditions are met. This is the view that now seems to predominate.

Several studies have shown that mass media campaigns promote health knowledge (Maibach et al., 1991), modify attitudes (Farquhar, 1977), and may change behaviour (Ershoff et al., 1990), suggesting that simple messages are best understood when they are transmitted visually, as on TV or videos (Chaiken & Eagley, 1976).



Donovan and Owen (1994) claim that mass media health promotion campaigns are most influential in the pre-contemplation and contemplation stages of behaviour change -explained in Chapter Two- by raising the salience and personal relevance of the issue. They are of moderate influence in the preparation stage, by reinforcing perceptions of self-efficacy and maintaining salience of the perceived benefits of adopting the recommended behaviour. The least influence of mass media is seen in the action and maintenance stages, where beliefs and attitudes are well established and where socio-environmental influence on the achieved behaviour are greatest.

Hubley (1993) agrees with this when he suggests that mass media can provide the necessary background information for change, by raising awareness and attracting interest, but are usually insufficient on their own to lead to trial and behaviour adoption, at which face to face communication is required.

According to Downie and his colleagues (1996), the most conspicuous part of health education in the UK are the high-profile mass media campaigns mounted by the national health education/promotion agencies and, increasingly, by medical charities and local health promotion services.

The 1992 BBC/HEA 90 minutes *Health Show* TV programme reached 8 million people. Among a sample of people who had written for follow-up materials, 75% reported making long-term change in lifestyle (British Market Research Bureau, 1993).

Moreover, since 1989, UK immunisation rates for childhood diseases have risen rapidly. Of mothers who reported that they saw the 1991 advertisements and took their child to be immunised, 17% cited TV as the major influence on their decision (HEA, 1992).

A study showed that the vast majority of Egyptian mothers who knew how to give ORT learned to do so from TV (Foege, 1989). Another study revealed that the TV health and social educational series; *The Family House* has been watched



by almost 95% of Egyptian adult population, and about 80% of them reported learning health messages as a result (Elkamel, 1995).

A soap opera addressing family planning concerns, *Accompaname*, has been credited with being "the determining factor in the drop of Mexico's population growth rate from 3.1 to 2.5% during the period it was aired from 1977 to 1978 (Galindo & Poidexter, 1986).

Different people may have different explanations for these varying findings. These findings are largely connected to the methods of studies employed, the issue(s) each study discusses and to the sociological variations of the samples involved, including age, gender, social class and education. Moreover, the author would say, mass media may play different roles in different societies: western or eastern, traditional or modern, rich or poor, etc. However, each study concludes in a philosophical explanation by the researcher, largely depending on how the issue was conceptualised.

These findings should not be interpreted as necessarily indicating causal relationships between mass media, and the reported behavioural change. In almost all of these cases, specific services, legislation and other structural adjustments, as well as other interpersonal health education programmes, were synchronised with such mass media initiatives. Nonetheless, it is reasonable to assume that the mass media component made a significant contribution.

Furthermore, Rogers (1992) debates that some of healthy life-style changes occurred naturally and spontaneously as a part of long-term social changes, but some happened in response to planned, media-centred preventive health campaigns.

Simple straight-forward messages can be conveyed to trigger positive behaviour in motivated people but will not produce attitude or behaviour change in resistant individuals. Complicated health issues and the learning of complex motor skills, such as breast-feeding can not be conveyed by mass media. The



same applies for society sensitive issues such as AIDS or sexually transmitted diseases control or family planning.

On the other hand, mass media can be utilised for drawing attention and attracting awareness of community changes. Mass media in Libya, in particular TV, were used to define smoking as a public health issue of concern to the population at all levels. The advocacy campaign led to legislative changes when smoking became, in the late eighties, prohibited at health services and all public offices, forbidden on public transport and banned from advertising.

Nevertheless, today, the effectiveness of the national TV channels should be questioned. Now, there is a great competition for viewers with the increasing popularity of satellite TV, at which competing channels attempt to increase entertainment based programmes and decrease factual programmes.

From another point of view, however, the author would comment that mass media, particularly TV advertising and role models, may have a negative influence on health behaviours, such as smoking, alcohol drinking, unhealthy food, and unsafe sex, especially with teenagers.

Preference for print media among the health education media, in the present research, ranges according to the health issue and the target audience. The relatively high literacy rate in Libya –82% in 1995- (LSMCH, 1997) supports the Libyans to choose print media as source of health education.

The officials prefer posters, booklets and leaflets over the newspapers, magazines and books. However, the general public prefer the newspapers and magazines over the other print materials. Booklets, leaflets and posters are recommended to be used also in the case of targeting the health services' visitors.

Booklets and leaflets can be useful especially for sensitive subjects, such as AIDS and other sexually transmitted diseases control, when people are too shy to ask but can pick up a booklet or a leaflet and read the given information.



Booklets and leaflets can be used for child and maternal health education in health centres or alongside patient education in a hospital setting.

Production of posters has dominated the work of many health education services. They have been given too much emphasis, compared with more effective approaches (Hubley, 1993). Park & Park (1997) see posters as to have much less effect in promoting healthy behaviours than the health educators would hope. Hubley (1993) considers them as useful mainly to bring a topic to the attention of the community, reinforce a message that the public is receiving through other channels such as radio and face to face, and provide a talking-point for discussion. Many people cannot recall seeing the poster, let alone remember the message.

Hotham (1995) looked at the accuracy of information regarding pregnancy in women's magazines and found an accuracy rate of 78%. The misinformation present in the magazines could lead to anxiety and unnecessary changes in behaviour.

When it is suggested that health education programmes be directed at children, teenagers or youth, the school setting is the most preferred medium for communication. School curricula, teachers, social workers, booklets, leaflets, posters, school visits and school activities are the recommended mediators of school health education. The enrolment rate to education in Libya supports the use of school setting in health education. Table 7.75 demonstrates enrolment rate for the age groups between 6 and 24 years in 1995 (NADI, 1996a).

Age Group	Males	Females	Total
6-11 (Preparatory school)	89.4	89.0	89.2
12-14 (Primary school)	64.2	68.1	66.1
15-17 (Secondary school)	43.4	46.4	44.9
18-24 (Higher education)	14.5	13.8	14.2
6-24 (All education stages)	79.7	73.2	74.9

Table 7.75: Enrolment rate for the age groups between 6 and 24 years in 1995.



School is an important setting for educating young people about healthy behaviours. The school environment has a major role to play in working towards placing the healthy practices being seen as the norm within the society.

The Alma Ata Declaration on Primary Health Care (WHO-UNICEF, 1978) accorded the education sector a major role when stated:

“Schools could provide the efficient means to attain all of the eight components of primary health care and could ensure that young people can be educated to have a good understanding of what health means, how to achieve it, and how it contributes to social and economic development”.

The Adelaide Statement for Health Promotion (1988) calls for reorienting existing curricula towards health promotion.

Extensive research has been conducted around the globe on the role of school in health education and promotion. A literature review by Tones and Tilford (1996), for example, concluded that schools are widely seen as having a key role in health education whether the desired outcomes are changing behaviours or the personal and social skills associated with empowerment. Kolbe (1985) reviewed 15 studies and revealed that school based health education programmes consistently improve targeted health knowledge, attitudes and skills and inconsistently improve target health behaviours. The International Union for Health Promotion and Education (IUHPE, 1999) assessed 20 years evidence of health promotion impacts and found that schools are cost-effective sites for health promotion interventions. The effectiveness and sustainability of school health is governed by how closely health promotion interventions are linked to the primary business of schools in developing the educational skills and knowledge base of young people.

On the other hand, schools can create an educated population who are the better able to make use of any health education they receive in later life from sources such as newspapers, magazines, books and booklets or leaflets. School health education, at early ages, may add to this effect.



In Canada, for example, the prevalence of smoking among women declined by only 7% between 1977 and 1981, but among women with a post-secondary certificate or diploma it declined by 25% and among women with a university degree it declined by 41% (Terris, 1984). In the United States, the prevalence of cigarette smoking declined from 1974 to 1987 by only 7% in persons with less than 12 years of education, 13% in those with 12 years, 24% in those with 13-15 years, and 39% in those with 16 or more years of education. In 1987, the prevalence of cigarette smoking was 41% in the first group, 32% in the second, 27% in the third, and only 17% in the last, most highly educated group (US Department of Health & Human Services, 1990).

Moreover, the school environment represents a part of the 'hidden curriculum' of the school. This includes good provisions of sanitation, clean water and facilitates for hygienic preparation of food. Teacher behaviour in schools is very important, since they represent role models for their pupils. Covering health issues in school activities can have a significant effect on the students' attitudes and behaviours. These include the school radio station, music or drama activities, art and academic contests, school newspapers or magazines, and many other activities. The school environment supporting health has been recently internationally declared under the notion of "Health Promoting Schools".

Sport and youth clubs or camps are recommended settings, by the study participants, to reach the youth when addressing related issues. These clubs and camps are the appropriate setting for the indicated age group. This is, in the author's opinion, largely for two main reasons; a) they are places to reach youth in non-formal, but entertainment way, and b) there where youth out of academic institutes can be reached.

Parents, patrons, teachers and social workers were selected as mediators for educating children, teenagers or youth. It is not always the individual who makes the decisions and should be the target for a behaviour change. Individual's behaviour can be influenced by social pressure made by parents and other members of the family or the community, including the teachers. Education of



young generation concerning smoking prevention, AIDS & drug abuse control and physical exercise promotion can be directed at the social pressure makers. The mother or both of the parents at home make the key decisions in the family and some health education interventions have to involve them, the gate-keepers. These interventions include those addressing hygiene & sanitation, healthy food & proper nutrition, immunisation, child health and accident prevention.

Parents act as role models for their children and as such can reinforce healthy and unhealthy behaviours. Educating parents about healthy behaviours and the role of the family may be useful in helping to motivate children to healthy practices. Research conducted by Charlton (1984) into the influence of family on teenage smoking has revealed that young people from homes where no adult smokers or from homes where parents are likely to disapprove of smoking are less likely to become regular smokers.

The lecture and seminar technique of communication is usually recommended as a medium of future health education in Libya, by both of the study groups. Health issue and target group have no influence on the preference of the lecture or seminar over the other media. To reach people at their work place, the lecture technique is recommended. This includes targeting industry labour or military personnel. This technique, also recommended for use in communicating with the health services' visitors at the health care setting in addition to the use of one to one communications by the health professionals. Part three of the present research will elaborate on the role of health professionals in health education.

The lecture is one of the oldest teaching methods around. The advantages of the lecture or seminar that they can be economical, practical, easy to use, can impart information, can influence opinion, and can stimulate thought and critical thinking. The disadvantages are that lecturing involves skills that may be difficult for the lecturer to master, that the audience is generally passive (and therefore less likely to learn), and that the lecture approach is not suited to the learning of complex skills. Lectures and seminars may incorporate dialogue between the lecturer and participants. This overcomes the limitation of one way learning.



The efficacy of the lecture as a means of education is unquestioned (Egger et al., 1999). What is less certain, however, is the comparative effectiveness of the lecture in contrast to other techniques such as discussion groups, educational films and videos. In deed, each technique has its advantages under different conditions. Research carried out by Green (1978) suggests that the lecture is less effective than group discussion and other methods where there is a need for attitudinal change or the development of problem-solving or values-clarification skills. Although the lecture is a valuable technique, it may be overused or used in situations where it is not totally appropriate.

Group health education techniques offer an intermediate approach between one to one approaches and wider community appeals through mass media. Gatherer and colleagues (1979) and Park & Park (1997) argue that the one-to-one health education approach is more effective than are group methods, and that the least effective strategy is that involving the relatively impersonal mass media ones.

In the cases of generalising health messages to all public groups or targeting the adult generation in particular, one of the recommended media for most of the issues is the mosque.

Islamic life-styles embrace numerous positive patterns promoting health and rejecting any behaviour which is contradictory to health. Islam calls for personal hygiene & sanitation, proper nutrition, dental health, breast-feeding, child health and many other healthy practices. Since all Libyans are Muslim, prevention and control of smoking & substance abuse, alcohol drinking and sexually transmitted diseases, within the Libyan community, can largely be supported in the mosques and by religious teachers.

Mosque health education permits some limitations. Adult behaviour is more rigid than that of younger people, because adult behaviour has been formed over a longer period of time. Adult and young people need different educational techniques. The same applies for the other numerous educational, cultural and social groups gather in the mosque for the Friday sermon. Other limitations to



group education approach are applicable here, including the disadvantage of one way direction. This can be overcome in the mosque summer lessons for children or the evening religious lessons for adults, in which discussion is facilitated. People who are well informed about health issues, and have received appropriate training and equipped with necessary communication skills can give these lessons.

The general public accorded the role of scouts in health education some importance. Scouts are recommended mediators to reach children and youth within most of health areas. This represents an application of child to child or youth to youth education model. The health officials, however, did not accord scouts the same importance as did to them by the general public participants. The Libyan Scout Movement is considered active and has received the WHO award for smoking prevention activities. The general public acknowledge the practice of scouts in health education and expect to see more. The health officials might not be much aware of the scouts' programmes and their importance, at which most of scouts' activities are isolated from health sector –or the other way around- and lack co-operation.

When 'hard-to-reach' groups are suggested to be targeted, home visits are the recommended technique to achieve this aim. These groups include mothers, housewives, aged or disabled people, and children before school age. Areas in which education is needed include Personal hygiene & Sanitation; Child Health; Maternal Health; Breast-feeding.

Since cinemas and theatres in Libya are not very active and do not attract people as the other media do, participants regard them at a lower level. Moreover, evidence on the effectiveness of these settings to promote health is not established within the reviewed literature.

The use of the Internet in Libya is not yet widely spread. Accordingly, it has been indicated by a number of participants to mediate health messages towards the new generation, but it is not the preferred medium of communication.



In most of the health issues, and to reach most of the suggested groups, a recommended combination of educational media is demonstrated. This is obvious in the case of targeting the young generation, at which the use of a combination of school setting and TV is perceived to be useful. A chosen combination of communication channels tends to have a synergistic effect. It is mutually reinforcing, and can carry different types of information. TV spreads information rapidly and at low cost. On the other hand the opportunity of two way interaction and obtaining feed back gives face to face communication a powerful advantage

The Three-Community Study in California represents an example of this combination. The two study communities received an intensive media campaign aimed at modifying risk behaviours, to reduce incidence of cardiovascular diseases, in the entire community. In addition in one of the two study communities, a number of individuals who had a higher risk of cardiovascular diseases were randomly selected to participate in an intensive, face-to-face instruction programme designed to modify risk behaviours. The media campaign included about three hours of TV programming, over 50 TV spots, approximately 100 radio spots, several hours of radio programming and a variety of materials for newspaper columns, stories, and advertisements.

Evaluation results indicated that residents of the two towns receiving the media campaign, showed greater knowledge about cardiovascular diseases and its associated risk factors, and demonstrated significant reductions in fat intake and plasma cholesterol relative to the no-intervention, comparison town. Over the intervention, period, the total risk of cardiovascular diseases was estimated to have declined by approximately 17% in the intervention towns, while it increased by over 6% in the no-intervention town. The greatest in the risk (30%) occurred in the individuals in the town who received intensive instruction (Maccoby, 1977).

A campaign to reduce tobacco smoking in an experimental area in Australia incorporated a combination of health educational media. A 6-week mass media programme was run using TV and radio. Teachers in schools' setting and doctors in hospitals' setting participated in this campaign as well. After three



months, a survey concluded that the experimental area experienced a drop of 11.4% of smokers maintained over three months (McDonald, 1983).

In south Australia, only 50-55% of children received the measles vaccine: 360 cases per year needed hospitalisation due to measles. Twenty-seven per cent of 21-30 year old females were not immune to rubella (Bowden, 1981). TV commercials which had been market-tested, radio commercials and a controversial poster on the rubella theme were developed. Informal news cover on the themes related to immunisation was developed to keep the story alive in the mind of the public. Attention was given to community groups to encourage them to the subject and the knowledge of professionals on immunisation was updated. Services were made more readily available through local councils and schools to enable easy access to immunisation. Measles immunisation rates up 64% and rubella rates up 57% (SAHC, 1982).

A number of studies have shown that different messages and intervention strategies are more or less appropriate for people in different stages of behaviour change (Prochaska et al., 1994). For example, Donovan and his colleagues (1997) showed that pre-contemplating smokers reacted differently to a set of anti smoking advertisements compared with the reaction of contemplating smokers. Hubley (1993) suggests the use of mass media to raise awareness and attract interest and the support of face to face communications, at the next stage, in order to lead to trial and behaviour adoption.

At the end of this discussion, the author wants to point out that a number of models are developed for conducting a successful health education and promotion programmes.

A model developed by Puska and colleagues (1985) emphasises that programme planning and evaluation should include the following key steps to help individuals to modify their behaviour:

1. Improved preventive services to help people to identify their risk factors and to provide appropriate attention and services.



2. Information to educate people about the relationship between behaviours and their health.
3. Persuasion to motivate people and to promote the intentions to adopt the health action.
4. Training to increase the skills of self-management, environmental control, and necessary action.
5. Social support to help people to maintain the initial action.
6. Environmental change to create the opportunities for health actions and improve unfavourable conditions.
7. Community organisation to mobilise the community for broad-ranged changes (through increased social support and environment modification) to support the adoption of the new life-styles in the community.

These make up a range of strategies for better health and improved quality of life. These strategies address intra-personal and interpersonal factors underlying risk factors of health, and embrace broader policy level approaches aimed at the socio-political or physical environment, addressing the risk conditions for health. Research in this field indicates that health promotion interventions are more likely to be effective where combinations of strategies are employed (Steckler et al., 1995).

Many of the health education and promotion interventions around the globe attempt at implementing this model or similar ones. The immunisation programme in Libya represents a typical national example. Health education activities supporting immunisation incorporated different techniques including mass media and face to face communications. The activities were directed at individuals, groups and populations, aiming at achieving educational, motivational, organisational, economic, regulatory & technological objectives leading to behavioural and environmental changes.

In the first part of this study, the national programme of immunisation is estimated, by the health officials, to lead the health promotion programmes in the country with connection to the positive role of health education activities.



An international example for multiple-approach health promotion is the North Karelia project, in Finland, to reduce rates of cardiovascular diseases. A number of strategies were employed in attempting to achieve the programme's objectives. One strategy involved the provision of information about the cardiovascular problem, factors such as smoking and diet that contributed to the problem, the kinds of things that the project would be doing, and how to change behaviour to prevent cardiovascular diseases. Educational material was prepared for the mass media, and community members were urged to discuss the information among themselves. Communications came not only from the mass media, but from a trained group of informal opinion leaders from the community.

Another strategy utilised by the programme involved the training of the population in the kinds of skills they would need to change the behaviours that were associated with risk of cardiovascular diseases. The project enlisted aid of community organisations in this process, and was assisted by a housewives' organisation with over 300 local clubs in teaching people new food preparation skills that would lower fat intake. The programme also attempted to build on the natural support systems of the community emphasising the desirability of individuals in families, work groups, and neighbourhoods working together to achieve the desired changes. Self-help groups were created to assist people to stop smoking and change their diet. The individuals who had been trained as informal opinion leaders also encouraged people to provide support to one another, either in self-help groups or in less formal ways, in order to change their behaviour.

An additional strategy focused on making environmental changes that would facilitate and reinforce the changes that people were asked to make at the individual level. Businesses and institutions were encouraged to introduce smoking restrictions, local dairies and sausage-makers were asked to contribute by producing low-fat products, and local shopkeepers were involved in featuring low fat items on their shelves. The final strategy was that of community organisation. Project leaders were in constant contact with local community leaders, including doctors, politicians, individuals working in the mass media, and leading business people. Project leaders were represented on many local boards and committees,



and the trained network of local leaders was also enlisted to represent the project's interests at the local level.

Results of the evaluation showed significant reductions in cardiovascular diseases risk factors (Puska et al., 1985 & Vartiainen et al., 1986).

Another example of the multiple-approach in health education and promotion is the Stanford Five City Project began in California in 1978 (Maccoby & Altman, 1988). The project involved of three components: broadcast media programs, print programs, and community interpersonal programs. The broadcast media strategies include TV and radio series, talk shows, news series, public announcements, and TV and radio spots designed to make people aware of health issues, provide people with specific information about health-promoting behaviours, and encourage them to adopt healthy-promoting attitudes and behaviours. The print media materials consisted of newspaper articles, pamphlets, books, self-help kits, and the like, which could provide more detailed information than the broadcast media. The community interpersonal programs involved many groups in the community schools and colleges, work sites, voluntary organisations, health professionals, etc... in a variety of programs. The strategies utilised ranged from more traditional health education approaches such as lectures and classes to more innovative approaches involving competitions and use of local opinion leaders. In addition, attempts were made to effect environmental changes that would support the kinds of individual changes that residents were asked to make. For example, restaurants and grocery stores were asked to highlight heart-healthy items in their establishments.

The evaluation results show significant increase in health-related knowledge, and reductions in blood pressure and pulse rate. The risk of cardiovascular diseases was estimated to be reduced.

Two additional examples used a multiple risk factor, multiple channel intervention include the Minnesota Health Programme and the Pennsylvania Country Health Improvement Programme. Both of the programmes utilised three component strategies in achieving their goals: a media component, a direct



education component, and a community organisation component. Evaluation of the programmes demonstrated their success (Blackburn et al., 1984; Stunkard et al., 1985).



**CHAPTER EIGHT**  
**(PART THREE)**

**HEALTH PROFESSIONALS' ROLE  
IN HEALTH EDUCATION:  
PERCEPTIONS AND ACTIONS  
FOR IMPROVING THE SERVICE**



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## ***CHAPTER EIGHT (PART THREE)***

### ***HEALTH PROFESSIONALS' ROLE IN HEALTH EDUCATION: PERCEPTIONS AND ACTIONS FOR IMPROVING THE SERVICE***

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#### **8.1 METHOD**

##### **8.1.1 Study Population**

The study population included health professionals, from different backgrounds and within different fields of health services.

##### **8.1.2 Research questions**

The questionnaire included closed questions, designed to understand health professionals' perceptions on health education, to identify the barriers, to suggest the solutions and to determine the needs for a more effective role for health professionals in health education and promotion (see Appendix E, page 388).

Participants were requested to tick in front of the perceived correct answer; to what degree they see that health professionals should have a responsibility for health education, how they consider the importance of health education by health professionals, and how they assess the effectiveness of the existing role of health professionals in health education.



Participants were also asked to tick in front of the degree of agreement they perceive against each of a list of barriers for delivering effective health education by the health professionals, and to suggest others, if any. All indicated barriers for health professionals' role in health education in the reviewed literature were presented in this questionnaire. A list of related possible suggested solutions for improving health professionals' role in health education were presented as well, in order to select the degree of agreement they have regarding each solution. Other solutions can be suggested as well. As per Likert scale for measuring attitudes, five degrees of agreement were presented against each point; strongly agree, agree, uncertain, disagree, and strongly disagree. Degrees of agreement of participants are to be translated into scores as follows:

Degree of agreement	Score
Strongly agree	+2
Agree	+1
Uncertain	0
Disagree	-1
Strongly disagree	-2

### 8.1.3 Variables

Variables in this questionnaire included; gender (male or female); profession (physician with determining speciality if applicable, dentist, pharmacist, nurse, midwife, health visitor, dietician, community health technician, health administrator, or another to be specified, if any); qualification (PhD or equivalent, MSc or equivalent, BSc or equivalent, Intermediate Diploma, Secondary school, or Primary school or lower); and field of work (curative medicine, preventive medicine or another to be specified, if any).



Some health professionals provide service for both preventive and curative medicine purposes. They are based at specialised services such as radiology centers, oral health and dental services, medical laboratories and community or private pharmacies. Services to the general public are provided at these centers for preventive as well as for curative purposes. Accordingly, a third option was presented within the questionnaire ‘Another’ to select it in this case.

**8.1.4 Piloting and procedure**

This form of questionnaire was revised by the members of the National Committee for Health and Social Education, who represented part of the piloting sample, which included 50 subjects.

In this part of the research, 500 copies of the questionnaire were handed out, during 1998 and 1999, to the study population personally, with the aid of colleagues, during one-to-one meetings or one-to-group meetings at the health centres, or during health or medical conferences. Completed questionnaires were collected either on the spot or during one of the following days.

**8.2 RESULTS**

**8.2.1 Response Rate**

Out of the distributed 500 copies, 300 copies of the questionnaire were completed and returned (response rate is 60%), as shown in Table 8.1.

No. of targeted people	No. of respondents	Percentage
500	300	60

Table 8.1: Response rate.

**8.2.2 Description of Participants:**

Tables 8.2 and 8.3 distribute the participants according to their gender, and profession.



Gender	No. of participants	Percentage
Male	178	59.33
Female	122	40.66
Total	300	100.00

Table 8.2: Distribution of participants according to their gender:

Profession	No of participants	Percentage
Physician	130	43.33
Dentist	22	7.33
Pharmacist	32	10.67
Nurse	21	7.00
Midwife	3	1.00
Health visitor	26	8.67
Dietician	2	0.67
Community health technician	17	5.67
Health administrator	17	5.67
Others	30	10.00
Total	300	100.00

Table 8.3: Distribution of participants according to their profession:

Physicians according to their speciality are shown in Table 8.4.

Physician speciality	No. of participants
General Practice	29
Dermatology	5
Internal medicine/Cardiology	29
Ophthalmology	5
Nephrology	1
Gynaecology & Obstetrics	24
General surgery	10
Radiology	2
Urology	1
Family & community medicine	6
Ear, Nose & Throat (E.N.T)	1
Orthopaedics	2
Paediatrics	14
Anaesthesia	1
Total	130

Table 8.4: Physicians according to their speciality.



Professions of participants other than the listed ones are shown in Table 8.5.

Other professions	No. of participants
Laboratory technician	7
X-Ray technician	2
Dental technician	4
Assistant pharmacist	5
Environmental health technician	1
Renal dialysis technician	1
First aid & relief technician	3
Medical geography specialist	1
Optics technician	1
Psychologist	1
Sociologist	1
Biologist	1
Medical equipment operator	2
Total	30

Table 8.5: Professions of participants other than the listed ones.

Tables 8.6 and 8.9 distribute the participants according to their field of work and leading qualification respectively.

Field of work	No. of participants	Percentage
Curative medicine	160	53.33
Preventive medicine	68	22.66
Others	72	24.00
Total	300	100

Table 8.6: Distribution of participants according to their field of work.

Qualification	No. of participants	Percentage
PhD or equivalent	24	8.00
MSc or equivalent	25	8.33
BSc or equivalent	172	57.33
Intermediate Diploma	63	21.00
Secondary school	4	1.33
Primary school	12	4.00
Total	300	100

Table 8.7: Distribution of participants according to their qualification.



8.2.3 Health Professionals’ responsibility for health education

In response to the question soliciting the view of the participants on the responsibility of health professionals for health education, participants selected one answer among the presented ones. Number of participants who selected each answer, with their percentage of the participants who answered the question are shown in Table 8.8. Classification of participants according to their field of work is also shown in this table.

Responsibility	All fields Of work <i>n=300=100%</i>		Curative medicine <i>n=160=53.33%</i>		Preventive Medicine <i>n= 68=22.66%</i>		Others <i>n=72=24.00%</i>	
	No.	%	No.	%	No.	%	No.	%
Yes, it is an integral part of health professionals’ role	257	86.24	132	83.02	57	83.82	68	95.77
A limited responsibility	21	7.05	18	11.32	2	2.94	1	1.41
Only the responsibility of health professionals working in the preventive services	5	1.68	2	1.26	2	2.94	1	1.41
Only for "at risk groups"	4	1.34	3	1.89	1	1.47	0	0.00
No, it is not their responsibility at all	2	0.67	2	1.26	0	0.00	0	0.00
Uncertain	9	3.02	2	1.26	6	8.82	1	1.41
Total participants answered the question	298	100	159	100	68	100	71	100

Table 8.8: Responsibility of health professionals for health education.

8.2.4 Importance of health education by health professionals

Importance of health education by health professionals is seen by the participants according to Table 8.9. It presents the number of participants who selected each answer, among the presented ones, with their percentage of the participants who answered this question. Classification of participants according to their field of work is also shown in this table.



Importance	All fields of work <i>n</i> =300=100%		Curative Medicine <i>N</i> =160=53.33%		Preventive Medicine <i>n</i> = 68=22.66%		Others <i>n</i> =72=24.00%	
	No.	%	No.	%	No.	%	No.	%
Very important	226	75.84	113	71.07	55	80.88	58	81.69
Important	69	23.15	44	27.67	13	19.12	12	16.90
Of little importance	1	0.34	1	0.63	0	0.00	0	0.00
Not important	2	0.67	1	0.63	0	0.00	1	1.41
Uncertain	0	0.00	0	0.00	0	0.00	0	0.00
Total participants answered the question	298	100	159	100	68	100	71	100

Table 8.9: Importance of health education by health professionals.

8.2.5 Effectiveness of the existing role of health professionals in health education in Libya

Participants assessed the effectiveness of the existing role of health professionals in health education in Libya as per Table 8.10. The table shows the number of participants who selected each answer, among the presented ones, with their percentage of the participants who answered the question. Classification of participants according to their field of work is also shown in this table.

Effectiveness	All fields of work <i>n</i> =300=100%		Curative Medicine <i>n</i> =160=53.33%		Preventive Medicine <i>n</i> = 68=22.66%		Others <i>n</i> =72=24.00%	
	No.	%	No.	%	No.	%	No.	%
Very effective	71	23.91	26	16.35	26	38.8 %	19	26.76
Effective	58	19.53	32	20.13	11	16.42	15	21.13
Of little effect	123	41.41	73	45.91	25	37.31	25	35.21
Not effective	36	12.12	22	13.84	4	5.97	10	14.08
Uncertain	9	3.03	6	3.77	1	1.49	2	2.82
Total number of participants answered the question	297	100	159	100	67	100	71	100

Table 8.10: Effectiveness of health professional's role in health education in Libya.



**8.2.6 Barriers to health professionals' role in health education**

Perception of the participants of the existence of presented, expected, barriers for delivering effective health education by health professionals is shown in Tables 8.11 to 8.25. They show the number and percentage of participants who selected each degree of agreement among the presented ones against each of the given barriers. Mean degree of agreement for each of these barriers is also shown in these tables. Classification of participants according to their field of work is presented as well.



1- Not enough time to practice health education (Table 8.11 ):

Degree of agreement	All fields of work					Curative medicine					Preventive medicine					Others				
	No.	%	Subtotal score (n x score)	Mean score (total score/n)		No.	%	Subtotal Score (n x score)	Mean Score (total score/n)		No.	%	Subtotal score (n x score)	Mean score (total score/n)		No.	%	Subtotal score (n x score)	Mean Score (total score/n)	
Strongly agree (+2)	37	12.37	74			19	11.95	38			14	20.59	28			4	5.56	8		
Agree (+1)	120	40.13	120			68	42.77	68			22	32.35	22			30	41.67	30		
Uncertain ( 0)	46	15.38	0			24	15.09	0			9	13.24	0			13	18.06	0		
Disagree (-1)	79	26.42	-79			38	23.90	-38			21	30.88	-21			20	27.78	-20		
Strongly disagree (-2)	17	5.69	-34			10	6.29	-20			2	2.94	-4			5	6.94	-10		
Total	299	100	81	0.27		159	100	48	0.30		68	100	25	0.37		72	100	8	0.11	

2- Health professionals lack communication skills (8.12):

Degree of agreement	All fields of work					Curative medicine					Preventive medicine					Others				
	No.	%	Subtotal score (n x score)	Mean score (total score/n)		No.	%	Subtotal score (n x score)	Mean Score (total score/n)		No.	%	Subtotal score (n x score)	Mean score (total score/n)		No.	%	Subtotal score (n x score)	Mean Score (total score/n)	
Strongly agree (+2)	101	34.01	202			56	35.44	112			27	40.30	54			18	25.00	36		
Agree (+1)	150	50.51	150			85	53.80	85			27	40.30	27			38	52.78	38		
Uncertain ( 0)	28	9.43	0			11	6.96	0			9	13.43	0			8	11.11	0		
Disagree (-1)	13	4.38	-13			5	3.16	-5			4	5.97	-4			4	5.56	-4		
Strongly disagree (-2)	5	1.68	-10			1	0.63	-2			0	0.00	0			4	5.56	-8		
Total	297	100	329	1.11		158	100	190	1.20		67	100	77	1.15		72	100	62	0.86	



### 3- Education & training of health professionals are carried out at the curative medicine services (Little knowledge of health education) (Table 8.13):

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	75	25.17	150		38	24.05	76		20	29.41	40		17	23.61	34	
Agree (+1)	134	44.97	134		75	47.47	75		29	42.65	29		30	41.67	30	
Uncertain (0)	55	18.46	0		32	20.25	0		12	17.65	0		11	15.28	0	
Disagree (-1)	29	9.73	-29		12	7.59	-12		6	8.82	-6		11	15.28	-11	
Strongly disagree (-2)	5	1.68	-10		1	0.63	-2		1	1.47	-2		3	4.17	-6	
Total	298	100	245	0.82	158	100	137	0.87	68	100	61	0.90	72	100	47	0.65

### 4- The language health professionals use is difficult to understand (Table 8.14):

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	34	11.37	68		14	8.81	28		11	16.18	22		9	12.50	18	
Agree (+1)	97	32.44	97		42	26.4 %	42		26	38.24	26		29	40.28	29	
Uncertain (0)	40	13.38	0		24	15.09	0		13	19.12	0		3	4.17	0	
Disagree (-1)	109	36.45	-109		67	42.14	-67		13	19.12	-13		29	40.28	-29	
Strongly disagree (-2)	19	6.35	-38		12	7.55	-24		5	7.35	-10		2	2.78	-4	
Total	299	100	18	0.06	159	100	-21	-0.13	68	100	25	0.37	72	100	14	0.19



**5- Health education is held to be of lower priority than is curative medicine in health services and by policy makers (Table 8.15):**

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	130	43.62	260		72	45.57	144		26	38.24	52		32	44.44	64	
Agree (+1)	109	36.58	109		65	41.14	65		19	27.94	19		25	34.72	25	
Uncertain (0)	41	13.76	0		15	9.49	0		18	26.47	0		8	11.11	0	
Disagree (-1)	17	5.70	-17		6	3.80	-6		5	7.35	-5		6	8.33	-6	
Strongly disagree (-2)	1	0.34	-2		0	0.00	0		0	0.00	0		1	1.39	-2	
Total	298	100	350	1.17	158	100	203	1.28	68	100	66	0.97	72	100	81	1.13

**6- Some professionals see health education as too trivial a job for them to do, or as merely the job of those working in the preventive health services (8.16):**

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	79	26.42	158		32	20.13	64		21	30.88	42		26	36.11	52	
Agree (+1)	115	38.46	115		74	46.54	74		23	33.82	23		18	25.00	18	
Uncertain (0)	24	8.03	0		14	8.81	0		4	5.88	0		6	8.33	0	
Disagree (-1)	70	23.41	-70		34	21.38	-34		17	25.00	-17		19	26.39	-19	
Strongly disagree (-2)	11	3.68	-22		5	3.14	-10		3	4.41	-6		3	4.17	-6	
Total	299	100	181	0.61	159	100	94	0.59	68	100	42	0.62	72	100	45	0.63



7- There is a lack of educational aids & materials (Table 8.17):

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	159	53.18	318		91	57.23	182		37	54.41	74		31	43.06	62	
Agree (+1)	116	38.80	116		65	40.88	65		21	30.88	21		30	41.67	30	
Uncertain (0)	11	3.68	0		2	1.26	0		5	7.35	0		4	5.56	0	
Disagree (-1)	10	3.34	-10		1	0.63	-1		3	4.41	-3		6	8.33	-6	
Strongly disagree (-2)	3	1.00	-6		0	0.00	0		2	2.94	-4		1	1.39	-2	
Total	299	100	418	1.40	159	100	246	1.55	68	100	88	1.29	72	100	84	1.17

8-Health services lack rooms & related facilities for conducting group health education (Table 8.18):

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	131	43.81	262		77	48.43	154		31	45.59	62		23	31.94	46	
Agree (+1)	117	39.13	117		61	38.36	61		27	39.71	27		29	40.28	29	
Uncertain (0)	26	8.70	0		11	6.92	0		4	5.88	0		11	15.28	0	
Disagree (-1)	18	6.02	-18		7	4.40	-7		4	5.88	-4		7	9.72	-7	
Strongly disagree (-2)	7	2.34	-14		3	1.89	-6		2	2.94	-4		2	2.78	-4	
Total	299	100	347	1.16	159	100	202	1.27	68	100	81	1.19	72	100	64	0.89



9- Factors such as family, commercial advertising, culture & traditional beliefs have a negative influence on health education (Table 8.19):

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	109	36.45	218		60	37.74	120		19	27.94	38		30	41.67	60	
Agree (+1)	130	43.48	130		71	44.65	71		28	41.18	28		31	43.06	31	
Uncertain (0)	36	12.04	0		15	9.43	0		17	25.00	0		4	5.56	0	
Disagree (-1)	21	7.02	-21		12	7.55	-12		4	5.88	-4		5	6.94	-5	
Strongly disagree (-2)	3	1.00	-6		1	0.63	-2		0	0.00	0		2	2.78	-4	
Total	299	100	321	1.07	159	100	177	1.11	68	100	62	0.91	72	100	82	1.14

10- Health education is of no or little interest to the recipient (Table 8.20):

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	41	13.71	82		21	13.21	42		10	14.71	20		10	13.89	20	
Agree (+1)	94	31.44	94		56	35.22	56		16	23.53	16		22	30.56	22	
Uncertain (0)	80	26.76	0		38	23.90	0		23	33.82	0		19	26.39	0	
Disagree (-1)	71	23.75	-71		38	23.90	-38		16	23.53	-16		17	23.61	-17	
Strongly disagree (-2)	13	4.35	-26		6	3.77	-12		3	4.41	-6		4	5.56	-8	
Total	299	100	79	0.26	159	100	48	0.30	68	100	14	0.21	72	100	17	0.24



11- Some professionals fear upsetting people (Table 21):

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	34	11.37	68		13	8.18	26		10	14.71	20		11	15.28	22	
Agree (+1)	93	31.10	93		54	33.96	54		20	29.41	20		19	26.39	19	
Uncertain (0)	70	23.41	0		41	25.79	0		19	27.94	0		10	13.89	0	
Disagree (-1)	87	29.10	-87		47	29.56	-47		14	20.59	-14		26	36.11	-26	
Strongly disagree (-2)	15	5.02	-30		4	2.52	-8		5	7.35	-10		6	8.33	-12	
Total	299	100	44	0.15	159	100	25	0.16	68	100	16	0.24	72	100	3	0.04

12-The presence of other people at the same place (e.g. the pharmacy) hinders discussions on private matters Table 8.22):

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	42	14.19	84		20	12.74	40		8	11.76	16		14	19.72	28	
Agree (+1)	74	25.00	74		43	27.39	43		16	23.53	16		15	21.13	15	
Uncertain (0)	89	30.07	0		49	31.21	0		28	41.18	0		12	16.90	0	
Disagree (-1)	78	26.35	-78		44	28.03	-44		12	17.65	-12		22	30.99	-22	
Strongly disagree (-2)	13	4.39	-26		1	0.64	-2		4	5.88	-8		8	11.27	-16	
Total	296	100	54	0.18	157	100	37	0.24	68	100	12	0.18	71	100	5	0.07



13- Health professionals are not invited to participate in community activities (table 8.23):

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	68	22.74	136		29	18.24	58		18	26.47	36		21	29.17	42	
Agree (+1)	124	41.47	124		74	46.54	74		22	32.35	22		28	38.89	28	
Uncertain (0)	75	25.08	0		43	27.04	0		18	26.47	0		14	19.44	0	
Disagree (-1)	26	8.70	-26		11	6.92	-11		9	13.24	-9		6	8.33	-6	
Strongly disagree (-2)	6	2.01	-12		2	1.26	-4		1	1.47	-2		3	4.17	-6	
Total	299	100	222	0.74	159	100	117	0.74	68	100	47	0.69	72	100	58	0.81

14- Some health professionals are not interested in cooperating & participating in community activities (Table 8.24):

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	34	11.37	68		17	10.69	34		9	13.24	18		8	11.11	16	
Agree (+1)	117	39.13	117		70	44.03	70		21	30.88	21		26	36.11	26	
Uncertain (0)	60	20.07	0		35	22.01	0		11	16.18	0		14	19.44	0	
Disagree (-1)	77	25.75	-77		34	21.38	-34		23	33.82	-23		20	27.78	-20	
Strongly disagree (-2)	11	3.68	-22		3	1.89	-6		4	5.88	-8		4	5.56	-8	
Total	299	100	86	0.29	159	100	64	0.40	68	100	8	0.12	72	100	14	0.19



15- There is information contradiction between different professionals (Table 8.25):

Degree of agreement	All fields of work					Curative medicine					Preventive medicine					Others				
	No.	%	Subtotal score (n x score)	Mean score (total score/n)		No.	%	Subtotal score (n x score)	Mean Score (total score/n)		No.	%	Subtotal Score (n x score)	Mean Score (total score/n)		No.	%	Subtotal score (n x score)	Mean Score (total score/n)	
Strongly agree (+2)	33	11.04	66			15	9.43	30			12	17.65	24			6	8.33	12		
Agree (+1)	114	38.13	114			65	40.88	65			19	27.94	19			30	41.67	30		
Uncertain (0)	73	24.41	0			34	21.38	0			21	30.88	0			18	25.00	0		
Disagree (-1)	74	24.75	-74			42	26.42	-42			15	22.06	-15			17	23.61	-17		
Strongly disagree (-2)	5	1.67	-10			3	1.89	-6			1	1.47	-2			1	1.39	-2		
Total	299	100	96	0.32		159	100	47	0.30		68	100	26	0.38		72	100	23	0.32	



Rank order of perceived barriers to health professionals' role in health education, according to the mean score (degree of agreement) given by the participants for each of the presented barriers, is shown in Table 8.26.

No.	Barrier	Mean
1	There is a lack of educational aids & materials	1.40
2	Health education is held to be of lower priority than is curative medicine in health services and by policy makers.	1.17
3	Health services lack rooms & related facilities for conducting group health education	1.16
4	Health professionals lack communication skills	1.11
5	Factors such as family, commercial advertising, culture & traditional beliefs have a negative influence on health education:	1.07
6	Education & training of health professionals are carried out at the curative medicine services (Little knowledge of health education):	0.82
7	Health professionals are not invited to participate in the community activities	0.74
8	Some professionals see health education as too trivial a job for them to do, or as merely the job of those working in the preventive health services:	0.61
9	There is information contradiction between different professionals	0.32
10	Some health professionals are not interested in cooperating & participating in community activities	0.29
11	Not enough time to practice health education	0.27
12	Health education is of no or little interest to the recipient:	0.26
13	The presence of other people at the same place (e.g. the pharmacy) hinders discussions on private matters	0.18
14	Some professionals fear upsetting people	0.15
15	The language health professionals use is difficult to understand	0.06

Table 8.26: Rank order of barriers to health professionals' role in health education.



**8.7 Suggested solutions for improving health professionals’ role in health education**

The mean scores, which represent the participants’ degrees of agreement about the presented suggested solutions to improve health professionals’ role in health education are shown in Tables 8.27 to 8.33. The tables illustrate the number and percentage of participants who selected each degree of agreement, among the presented degrees, against each of the suggested solutions. Classification of participants according to their field of work is presented as well.



**1- A signification proportion of education & training in the medical & health schools should be based in the primary health care services (Table 8.27):**

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	123	43.31	246		62	39.49	124		32	51.61	64		29	44.62	58	
Agree (+1)	130	45.77	130		78	49.68	78		23	37.10	23		29	44.62	29	
Uncertain (0)	20	7.04	0		12	7.64	0		3	4.84	0		5	7.69	0	
Disagree (-1)	10	3.52	-10		4	2.55	-4		4	6.45	-4		2	3.08	-2	
Strongly disagree (-2)	1	0.35	-2		1	0.64	-2		0	0.00	0		0	0.00	0	
Total	284	100	364	1.28	157	100	196	1.25	62	100	83	1.34	65	100	85	1.31

**2- Communication skills should be included within the teaching programmes for medical & health sciences students (Table 8.28):**

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	137	48.58	274		75	48.08	150		30	48.39	60		32	50.00	64	
Agree (+1)	132	46.81	132		74	47.44	74		28	45.16	28		30	46.88	30	
Uncertain (0)	11	3.90	0		5	3.21	0		4	6.45	0		2	3.13	0	
Disagree (-1)	2	0.71	-2		2	1.28	-2		0	0.00	0		0	0.00	0	
Strongly disagree (-2)	0	0.00	0		0	0.00	0		0	0.00	0		0	0.00	0	
Total	282	100	404	1.43	156	100	222	1.42	62	100	88	1.42	64	100	94	1.47



3- Continuing education on techniques of health education should be provided for the different health professionals (Table 8.29):

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	140	49.65	280		69	44.23	138		38	61.29	76		33	51.56	66	
Agree (+1)	138	48.94	138		86	55.13	86		23	37.10	23		29	45.31	29	
Uncertain (0)	4	1.42	0		1	0.64	0		1	1.61	0		2	3.13	0	
Disagree (-1)	0	0.00	0		0	0.00	0		0	0.00	0		0	0.00	0	
Strongly disagree (-2)	0	0.00	0		0	0.00	0		0	0.00	0		0	0.00	0	
Total	282	100	418	1.48	156	100	224	1.44	62	100	99	1.60	64	100	95	1.48

4- A number of health professionals should be specialised in the field of health education (Table 8.30):

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	120	42.40	240		53	33.97	106		36	58.06	72		31	47.69	62	
Agree (+1)	140	49.47	140		88	56.41	88		23	37.10	23		29	44.62	29	
Uncertain (0)	12	4.24	0		10	6.41	0		0	0.00	0		2	3.08	0	
Disagree (-1)	10	3.53	-10		5	3.21	-5		2	3.23	-2		3	4.62	-3	
Strongly disagree (-2)	1	0.35	-2		0	0.00	0		1	1.61	-2		0	0.00	0	
Total	283	100	368	1.30	156	100	189	1.21	62	100	91	1.47	65	100	88	1.35



5- Health professionals should be provided with educational aids & materials (Table 8.31):

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	172	61.21	344		96	61.54	192		38	62.30	76		38	59.38	76	
Agree (+1)	108	38.43	108		59	37.82	59		23	37.70	23		26	40.63	26	
Uncertain (0)	1	0.36	0		1	0.64	0		0	0.00	0		0	0.00	0	
Disagree (-1)	0	0.00	0		0	0.00	0		0	0.00	0		0	0.00	0	
Strongly disagree (-2)	0	0.00	0		0	0.00	0		0	0.00	0		0	0.00	0	
Total	281	100	452	1.61	156	100	251	1.61	61	100	99	1.62	64	100	102	1.59

6- Provision of suitable rooms & related facilities for conducting group health education should be facilitated (Table 8.32):

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	146	51.59	292		77	49.36	154		38	61.29	76		31	47.69	62	
Agree (+1)	124	43.82	124		70	44.87	70		22	35.48	22		32	49.23	32	
Uncertain (0)	9	3.18	0		6	3.85	0		1	1.61	0		2	3.08	0	
Disagree (-1)	4	1.41	-4		3	1.92	-3		1	1.61	-1		0	0.00	0	
Strongly disagree (-2)	0	0.00	0		0	0.00	0		0	0.00	0		0	0.00	0	
Total	283	100	412	1.46	156	100	221	1.42	62	100	97	1.56	65	100	94	1.45



7- Support of policy makers needs to be improved (Table 8.33):

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	169	59.72	338		95	60.90	190		32	51.61	64		42	64.62	84	
Agree (+1)	103	36.40	103		57	36.54	57		25	40.32	25		21	32.31	21	
Uncertain (0)	7	2.47	0		4	2.56	0		3	4.84	0		0	0.00	0	
Disagree (-1)	4	1.41	-4		0	0.00	0		2	3.23	-2		2	3.08	-2	
Strongly disagree (-2)	0	0.00	0		0	0.00	0		0	0.00	0		0	0.00	0	
Total	283	100	437	1.54	156	100	247	1.58	62	100	87	1.40	65	100	103	1.58

8- Enhancing the role of mobile health education groups is important (Table 8.34):

Degree of agreement	All fields of work				Curative medicine				Preventive medicine				Others			
	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)	No.	%	Subtotal Score (n x score)	Mean Score (total score/n)	No.	%	Subtotal score (n x score)	Mean Score (total score/n)
Strongly agree (+2)	161	56.89	322		82	52.56	164		38	61.29	76		41	63.08	82	
Agree (+1)	112	39.58	112		71	45.51	71		19	30.65	19		22	33.85	22	
Uncertain (0)	10	3.53	0		3	1.92	0		5	8.06	0		2	3.08	0	
Disagree (-1)	0	0.00	0		0	0.00	0		0	0.00	0		0	0.00	0	
Strongly disagree (-2)	0	0.00	0		0	0.00	0		0	0.00	0		0	0.00	0	
Total	283	100	434	1.53	156	100	235	1.51	62	100	95	1.53	65	100	104	1.60



Rank order of suggested solutions for improving health professionals' role in health education, according to the mean score which represent the degree of agreement given by the participants for each of the presented suggested solutions, is shown in Table 8.34.

No	Suggested solutions	Mean score
1	Health professionals should be provided with educational aids & materials	1.61
2	Support of policy makers needs to be improved	1.54
3	Enhancing the role of mobile health education groups is important	1.53
4	Continuing education on techniques of health education should be provided for the different health professionals	1.48
5	Provision of suitable rooms & related facilities for conducting group health education should be facilitated	1.46
6	Communication skills should be included within the teaching programmes for medical & health sciences students	1.43
7	A number of health professionals should be specialised in the field of health education	1.30
8	A signification proportion of education & training in the medical & health schools should be based in the primary health care services	1.28

Table 8.34: Rank order of suggested solutions.

8.3 DISCUSSION

The Alma Ata Declaration of Primary Health Care (WHO-UNICEF, 1978) and the Ottawa Charter for Health Promotion (1988) have recognised the need for reorientation of health services towards promoting health. The Mexico Framework for Countrywide Plans of Action (2000) identified the process of reorientation as a component of the mechanisms for action. The role of health professionals in health promotion has been advocated. Health professionals represent an essential element in community health promotion and education. A



variety of terms are used in the literature to cover the educational activities of health professionals and in health care services: health education, patient education, client education, patient counselling, health promotion, patient teaching and so on.

Secondary and tertiary levels of health education are supposed to be widely used approaches by health professionals and in health services, under the umbrella of patient education activities.

The educational component of health care in Libya remains under-emphasised. The present study is the first one in the country to study health professionals' perceptions on their role in health education. It is, to the author's knowledge, the first one world-wide to present 15 claimed barriers for a successful health education by health professionals, in order to make a comparison between them, with a participation of 300 health professionals.

The study involved health professionals in Libya, with different qualifications and from different specialities, different fields of work, and both genders. The aim of this strategy was to generalise the obtained results. The number of respondents in this study (300) is relatively high when compared with other studies for similar objectives.

### **8.3.1 Health professionals' responsibility for health education**

86.24% of the participants perceive that health education is an integral part of the role of health professionals. 7.05% see it as of limited responsibility by them. 3.02% are uncertain. The professionals involved in the curative field agree with those in the preventive field in this respect. The percentage of curative field professionals perceiving that health education represents an integral part of their role is similar to that of preventive field professionals. They are 83.02% and 83.82% respectively. However, 11.32% of curative field professionals see it as of limited responsibility where only 2.94% of the preventive field professionals reflect this view. 95.77% of professionals in other fields of work perceive that health education is an integral part of the health professionals' role.



Increasingly health education has been recognised as an essential element of health and medical professionals' responsibilities. The role of education varies between countries, but its development and place within the National Health Service in the UK may provide an illustrative example. Over the last two decades a number of official documents and reports have provided commitment to education and prevention in health services. These include: "Care in Action" (DHSS, 1981), Reports of the Royal College of General Practitioners (1981a & 1981b), Consultative Documents (DHSS, 1986 & 1987a), Project 2000 (UK CCNMHV, 1986), and Government White Papers (DHSS, 1987b & DOH, 1992).

In the USA, at a conference in 1964, the American Hospital Association recommended education as an integral part of patient care and thus direct responsibility of hospital personnel (American Hospital Association, 1972).

However, some health professionals have too narrow a concept of health and what is meant by health promotion and by health education (Ewles & Simnett, 1996). Accordingly, these professionals will tend to limit their responsibility for health promotion and education.

On the other hand, the findings of a study by Wood and colleagues (1989) indicate that general practitioners hold strongly positive attitudes to prevention, and it is suggested that the role of general practitioners as health educators should be further supported.

### **8.3.2 Importance of health professionals' role in health education**

75.84% of the participants consider health professionals' role in health education as very important. 23.15% consider it as important and 0.34% as of little importance. 0.67% see it as not important.

The obtained results on perceptions of health professionals concerning the responsibility for and importance of health education in their practice meet with



the author's hypothesis that they are willing to contribute actively in public health education.

A previous survey in the UK indicated that the general public most often turn to their general practitioner as their principle source of medical information. It has also been shown that patients generally approve of the role of the general practitioner as health educator (Wood et al., 1989).

Another survey in Australia found that 80% of people visit a general practitioner as their first reference for health matters, and many regard this as the most influential source of information (National Health Strategy, 1992).

Ninety-five percent of the randomly selected and interviewed general practitioners in a study agreed that patient education was important, and 61 % placed doctors' advice in the top three most effective methods of communicating health advice (Tapper-Jones et al., 1990). All interviewed post-graduate teaching doctors by Calnan and colleagues (1986) reported that prevention and health education are important in general practice. Another study by Coulter and Schofield (1991) revealed that general practitioners have very positive attitudes to roles in preventive care and health promotion.

On the other hand, a range of studies highlighted that health professionals may not believe that changing behaviour will affect risk factors. Many are even doubtful as to how appropriate it is to give life-style advice to patients (Calnan, 1991 & Imperial Cancer Research Fund, 1994).

In the present study, the percentage of preventive medicine professionals considering the role of health professionals in health education as very important (80.88%) is higher than that of curative medicine professionals (71.07%). This is an expected result. The work in the preventive field and primary health care setting should have a significant positive influence on the health professionals' perceptions towards health education. Another factor is that a significant proportion of professionals working at the preventive medicine field are expected to be qualified or trained in the fields of family and community health or



preventive medicine. Moreover, despite of the participants' qualifications, professionals working at the preventive medicine field are supposed to be preventive medicine oriented, before commencing to their work.

The other side of these explanations is applicable to the health professionals involved in the curative medicine field.

This result is in line with the author's opinion when he hypothesised that perceptions of health professionals working in the preventive medicine field on their role in health education are more optimistic than of those working in the curative medicine field.

During a workshop dealing with the community health planning model, participants from health professionals in Canada were asked to name the three most important health problems facing their community (Labonte, 1987). Their answers fell into three broad categories: medical, public health and socio-environmental. Not unexpectedly, medical and hospital-based professionals attending the workshop were inclined to see diseases as the major problem, public health practitioners gave prominence to health behaviours, and community workers believed that social conditions such as poverty and unemployment were the main problems.

### **8.3.3 Effectiveness of the existing role of health professionals in health education in Libya**

23.91% of the participants assess the existing role of health professionals in health education as very effective. 19.53% assess it as effective. 41.4% consider it of little effect and 12.12 as not effective. 3.03% are uncertain. The preventive medicine participants see the existing role of health professionals in health education as more effective than the curative medicine professionals do.



In part one of this research, the two groups of participants – the health officials and the general public- assessed the effectiveness of health professionals' role in health education at relatively lower levels.

Health professionals are expected to provide an important and effective role in health education and promotion because of the high contact rates with individuals and the perceived credibility of health professionals by the general public.

Smoking intervention programmes based on health professionals have resulted in significant reduction in smoking (IUHPE, 1999). The majority of patients considered that their chances of success were greater if a doctor administered the smoking intervention programmes and that having the results of lung-function and blood tests constituted a strong incentive to stop smoking (Egger et al., 1999).

General practitioner patient education has demonstrated success with many other health problems. Examples include HIV/AIDS control (Gallagher, 1989), back pain (Roland & Dixon, 1989), hypertension (Watkins et al., 1987), and the reduction of excessive alcohol consumption (Richmond et al., 1998 & IUHPE, 1999). On the other hand, evidence for effective education by health professionals on physical exercise and nutrition is insufficient (IUHPE, 1999).

#### **8.3.4 Barriers to health professionals' role in health education**

As explained earlier, the degrees of agreement of study participants were translated to scores, from strongly agree, agree, uncertain, disagree, and strongly disagree, to +2, +1, 0, -1, and -2. Accordingly, final scores had to be translated back to degrees of agreement. This leads to obtaining centesimal fractions, not integral figures, and analysis of results had to be on this basis.

The mean score for five barriers is over 1.00 and less than 2.00. This reflects the fact that the participants may have –in average- accorded then a score equals higher than “agree” but less than “strongly agree”. This gives these five



barriers a higher importance. They are: the lack of educational aids & materials; the low priority held for health education in health services & by policy makers; the lack of rooms & related facilities for conducting group health education in the health services; the lack of communication skills among health professionals; and the negative influence of factors such as family, commercial advertising, culture & traditional beliefs, on health education.

Three other barriers are considered less important by scoring them 0.50–1.00. They are: little knowledge of health professionals about health education as a result of receiving their education and training under the auspices of the curative medicine services; health professionals are not invited to involve themselves in community activities providing health education; and some health professionals see health education as too trivial an activity for them, or as merely the job of those working in the preventive health services. Other barriers are perceived to have lower importance.

One of the hypotheses of this study was that the lack of information on health education, disease orientation and poor communication skills are the main barriers to health professionals in occupying a more effective role in health education. However, according to the health professionals' perceptions in the present study, these are important barriers, but not the main ones.

Ninety-two percent of interviewed general practitioners in a previous study had encountered practical difficulties involving poor doctor-patient communication. Seventy-six percent of doctors highlighted lack of time as a barrier to providing more health advice for their patients and 54 % said that time constraints were a major difficulty in their practices (Tapper-Jones et al., 1990).

Previous studies have highlighted a number of barriers such as lack of time (Calnan, 1994), lack of financial incentives, lack of computerised age/sex registers (Calnan, 1991), fear of upsetting people (Williams et al., 1989), and administrative burden (Calnan & Corney, 1994).



A literature review by Hubley (1993) to studies aimed at identification of problems of communication between health professionals and their patients listed a number of problems. They are:

- The communication is carried out in a place where is a lot of noise and distraction;
- The person feels uncomfortable and distracted, is too self-conscious to discuss problems because of people overhearing or does not really trust the health educator;
- The health educator does not find out the real reasons for the problem, uses complicated language with unfamiliar terms, gives advice that is irrelevant or impossible to put into practice.
- People go away with doubts and questions they could not raise with the health professional;
- Most people want to be told more about their illnesses than the doctor is willing to say;
- Too much information is given; the person only remembers part of what was said during the meeting, especially if he/she is anxious and worried;
- There is a wide difference in background between the two persons without enough sharing of culture, perceptions, beliefs and values to allow communication and understanding;
- Insufficient time is available to find out what the person's problems really are or properly explain the facts;
- There is no follow-up to check if the advice is put into practice.

Coulter and Schofield (1991) found in a study that reported barriers to carrying out health promotion activities by health professionals are ranked as following: lack of time, patient's lack of interest in life-style advice, lack of financial incentive, lack of interest on the part of the doctor, too few practice staff, inadequate records and registers, inadequate premises, and the lack of computers. Rank order of barriers in another study by Coppel and Davis (1998) was as following: lack of resources, lack of time, poor interest from patients, and reluctance of patients to help themselves.



Ewles & Simnett (1996) said in this context that resource constraints may hinder the professions from achieving their potential in health promotion. There may be staff shortages and work overload, leading to less time available for long term health promotion work.

Furthermore, according to Tapper-Jones and colleagues (1990), difficulties to health professionals' role in health education may be organisational, attitudinal or due to deficiencies in knowledge or communication skills.

In the present study, lack of educational aids and materials is perceived as the most important barrier to the role of health professionals in health education, based on the mean score obtained. 53.18% of the participants strongly agree about the presence of this barrier and 38.80% agree. The degree of agreement by curative medicine professionals is stronger than that by the preventive medicine professionals.

The second barrier in the rank order is the perceived low priority given to health education in health services and by policy makers compared to curative medicine. 43.62% of the participants strongly agree about this barrier and 36.58% agree. Again curative medicine professionals designate this barrier more than the preventive medicine professionals do.

Lack of rooms and related facilities for conducting group health education in the health services is considered the third barrier in the rank order. 43.81% of the participants strongly agree about this, 39.13 agree, and 8.70% are uncertain. Health professionals in both of the fields of work –preventive and curative- have a similar view. It has been observed by the author, that the rooms designed for health education activities in some health centres were used by the centres managers as administrative offices.

Generally speaking, participants put the main barriers to health professionals' role in health education on the shoulders of the policy makers, the administrators and health services organisers. Although preventive medicine professionals agree with the curative medicine professionals to the same degree



regarding the third barrier, they don't do so with regard to the first and second ones. This is based on that health professionals can provide health education with the absence of educational aids and materials or the lack of policy makers' support.

The national health services in most -if not all- industrialised, as well as developing countries including Libya- has evolved as a treatment and care services for people who are ill, not as the major means of improving public health (Cochrane, 1972). This, in the author's view, is also true of Libya.

James Cowley, Ex. Director of Health Promotion Services, South Australian Health Commission, has commented on the perceptions of some health planners and policy makers and on health promotion priority within the health systems in South Australia. He said (1986):

"We generally received considerable support from the medical profession. It showed a high commitment to health promotion and the major professional medical groups were exceptionally supportive. There were a number of issues, however, which formed the basis of some opposition. They include:

- An inability to understand what health is among some health planners. Generally health planners have to deal with balancing accounts and ensuring hospitals do not overspend. It is huge step to move from this to more general thinking and long-term planning concerning how the actual nature of health experienced by the population can be improved. Some health officials could never get beyond seeing health promotion just as a short-term fad.
- An inability of health systems to look at effectiveness as much as efficiency. The systems concentrate on whether money adds up, not on whether expenditure in one area equals greater benefit than expenditure in another area.
- Health innovations usually have to be funded within standstill budgets.
- Much time is spent in health departments trying to survive the next political crisis rather than on long-term planning.
- Medical practice vested interests sometimes felt that it was their money being spent on health promotion. They thought that if one part of the system had been cut it must have been that money which was being spent on health promotion.



- A belief that health promotion is extremely expensive. One hundred thousand dollars spent on a campaign was seen as gross over-expenditure, while 10 times that amount being spent each day on equipment was seen as necessary”.

An Australian study revealed that hospital staff support for health promotion activities is high. However, sufficient funding, support from relevant personnel and availability of resources and training were identified as barriers to more hospital based health promotion activities being undertaken (Anderson et al. 1995). Most hospitals surveyed in Australia recognised the importance of patient education, but support was based on individual efforts resulting from initiatives taken in specialty areas rather than reflecting overall hospital policy (Degeling et al., 1990). In Canada, 37% of hospitals had health promotion policies, while 21% stated that health promotion was not part of their role (Bartlett & Jonkers, 1990).

Lack of communication skills among health professionals is considered the fourth barrier in the rank order. 34.01% of the participants strongly agree to this, and 50.51% agree. Preventive field professionals' agreement to this barrier is close to that of the curative field professionals, but slightly lower.

Boulton and colleagues (1984) and Rahman (2000) reported that the communication between doctor and patient is frequently poor and ineffective. It is the most common cause of complaint from patients or their relatives (Myerscough et al., 1992). Studies show that students do not automatically develop good communication techniques (Tamburrino et al., 1993).

Lack of knowledge about which approaches to health promotion are likely to be effective in different circumstance is a problem, so ineffective methods continue to be used (Ewles & Simnett, 1996).

This fact is acknowledged by a significant number of health professionals. Accordingly, some of them tend to rate their competence in providing primary prevention advice less highly than the desirability of providing such advice.



Factors such as family, commercial advertising, culture and traditional beliefs have a negative influence on health education is considered the fifth barrier to role of health professionals in health education. 36.45% of the participants strongly agree and 43.48% agree to this barrier. Agreement of the preventive field professionals to this barrier is lower than that of the curative field professionals.

The barrier of little knowledge of health professionals on health education as a result of receiving their education and training at the curative medicine services is perceived to be the sixth barrier in the rank order. 25.17% of the participants strongly agree 44.97% agree about this. 18.46% are uncertain. Degrees of agreement of the professionals in the preventive field and in the curative field are similar.

It can be argued that medical schools disease orient their students, and at the best they risk-factor orient the students. They concentrate on clinical sciences and conduct their training programmes focused on curative medicine services. "Public health, health promotion, disease prevention, preventive health, and health education" are terms which do not receive much attention within the medical schools' curricula. Primary Health Care Centres and Maternal & Child Health Units are not universally the sites for training medical students. For instance, medical students hear little about 'Teaching Primary Health Care Centres', but usually know a lot about 'Teaching Hospitals'. This author never heard about training a medical student at a 'Maternal and Child Health Centre' in Libya.

Many of the world's medical schools prepare doctors not to care for the health of the people but to engage in a medical practice that is blind to anything but disease and the technology for dealing with it. Sometimes even the cynical question is asked: does it really matter what kind of doctors we train? (O'Neill, 1984).

Twenty-six percent of surveyed general practitioners (Killoran et al., 1993) had had no health promotion training. Of the 72% who had training, only 37% had received it through medical education. Training needs included practice



organisation and management, communication skills, clinical training and use of computers.

The existing situation represents the dominance of treatment over preventive medicine. The clinicians, stress action for the patient who already has disease, rather than action to prevent people getting diseases in the first place. It is the approach of 'Fighting death' as viewed by McCarthy (1985).

Boulton and Williams (1986) said in this context: "the general practitioners approached the work of general practice in a way which is likely to inhibit them from putting their knowledge of health education and prevention into practice. They were largely disease-oriented, took a relatively narrow view of health education, and felt so constrained by circumstances as to respond to the presenting problem only.

With all the modern advances, however, the hospital became the natural workshop of the doctor. The value of primary health care, which could have kept many people out of the hospital was more and more ignored and the result was the neglect of their health (O'Neill, 1984).

22.74% of the participants in the present study strongly agree and 41.47% agree that health professionals are not invited to participate in community activities, in order to provide community health education, ranking this barrier the seventh among the others. Views of the preventive field and curative field professionals are similar.

The eighth barrier in the rank order is that some health professionals see health education as too trivial a job for them to do, or as merely the job of those working in the preventive health services. Participants' opinions range. 26.42% strongly agree and 38.46% agree to this barrier. 3.68% strongly disagree and 23.41% disagree to the barrier. 8.03% are uncertain. Degree of agreement of preventive field professionals is slightly higher than that of the curative field professionals.



Variations in enthusiasm for health promotion are evident between different health professionals. An interviewed practice nurse by Coppel & Davis (1998) said: "The general practitioners feel that health promotion is a waste of time, unless of course more money is involved". A general practitioner stated that: "Health promotion is a much harder subject to get a handle on".

Presence of information contradiction between different health professionals is ranked ninth among the presented barriers. Participants' perceptions are different. 11.04% of the participants strongly agree and 38.13% agree to this barrier. 1.67% strongly disagree and 24.75% agree to this barrier. 24.41% are uncertain. The agreement of preventive medicine professionals to this barrier is higher than that of the curative medicine professionals.

11.37% of the participants strongly agree and 39.13% agree to the point that some health professionals are not interested in co-operating and participating in community activities. 3.68% strongly disagree and 25.75% agree to this point. 20.07% are uncertain. The mean score given by the participants is less than 0.50. It is 0.32. This means that the participants slightly agree to this barrier. The participants' assessment ranked this barrier tenth in the rank order of the barriers to health professionals to conduct health education. Agreement of health professionals in the preventive medicine field is relatively lower.

Health professionals may still be under-utilised in performing a community-based health education role outside their clinical practice, despite their willingness to participate. Girgis & Sanson-Fisher (1996) identified lack of confidence due to inadequate training in, and information on, health promotion, as the main barriers to the community activities.

Ronald Labonte (1987) said in this context when commenting on Toronto health professionals' activities in the community: "Most of health professionals have neither the time nor the specialised skills to work as community organisers. Their primary community development role is to facilitate, rather than to initiate, they become resource persons for community groups developing themselves around a health issue or problem".



Nevertheless, it is not enough that health professionals be knowledgeable about matters that influence individual's health and educate individuals to improve behaviours. Their responsibilities are to include community activities towards the development and societal improvements.

Not enough time to practice health education is ranked eleventh. 12.37% of the participants strongly agree and 40.13% agree to this barrier. 5.69% strongly disagree and 26.42% disagree. 15.38% are uncertain. Preventive medicine professionals' agreement to this barrier is higher than that of curative medicine professionals. This, of course, is an unexpected view and calls for more detailed investigation.

Participants ranked the little or no interest of the recipient to health education as twelfth among the presented barriers. 13.71% of the participants strongly agree and 31.44% agree to this barrier. 4.35% strongly disagree and 23.75% disagree. 26.76% are uncertain. Curative medicine professionals nominate for this barrier more than the preventive medicine professionals do.

Generally, there is very little agreement or nearly uncertainty of the questioned participants to the remaining presented barriers. This consigns them to being perceived as of least importance. They include: the presence of other people at the same place (eg. the pharmacy) hinders discussions on private matters; some professionals fear upsetting people; and the language health professionals use is difficult to understand. Assessments of participants, in both fields of work, of these three barriers are different. Curative medicine professionals slightly disagree about the language barrier, while, preventive medicine professionals slightly agree. Fear of upsetting people is more respected as a barrier, by the preventive medicine professionals. Level of agreement of curative medicine professionals about the barrier of influence of presence of other people is greater than that of the preventive medicine professionals.



### **8.3.5 Suggested solutions for improving the role of health professionals in health education**

Participants' agreement to the suggested solutions to improve the service is higher than is their agreement to the presented barriers. Mean scores for these solutions range between 1.61-1.28. This means that the participants are more than agree to all suggested solutions.

Agreement as to the importance of solutions for improving the health professionals' role in health education mirrors their agreement about the perceived barriers in holding the main responsibility on the health system and policy makers.

Providing educational aids and improving support of policy makers are the most important solutions for improving health professionals' role in health education, according to the mean score given to them. Rank order of the presented solutions is as following: enhancing the role of mobile health education groups is third; providing the different health professionals with continuing education on techniques of health education is fourth; providing suitable rooms & related facilities for conducting group health education is fifth; including communication skills within teaching programmes for medical & health sciences students is sixth; specialising a number of health professionals in the field of health education is seventh; and carrying out a significant proportion of education & training in the medical & health schools in the primary health care services is eighth.

With regard to provision of educational aids and materials, 61.21% of the participants strongly agree and 38.43% agree. 0.36% (one person) is uncertain. None disagree. Degrees of agreement of preventive and curative medicine professionals are similar. 59.72% of the participants strongly agree and 36.40% agree to the need for improving the policy makers support to health education. Curative medicine professionals agree to this solution more than preventive medicine professionals do.



56.89% of the participants strongly agree and 39.58% agree to the need for enhancing the role of mobile health education groups. This agreement ranks this solution third among the presented ones. Assessment of both groups in this respect is similar.

The participants acknowledge the role of continuing education for health professionals on techniques of health education in order to improve the service ranking it the fourth among the suggested solutions. 49.65% of the participants strongly agree and 48.94% agree to this solution. Preventive medicine professionals' agreement is higher than that of the curative medicine professionals.

Provision of suitable rooms & related facilities for conducting group health education is considered the fifth solution in the rank order. 51.59% of the participants strongly agree and 43.82% agree to this solution. Preventive medicine professionals' support to this solution is slightly higher.

Preventive and curative medicine professionals' view to the importance of including communication skills within the teaching programmes for medical & health sciences' students in order to improve the service. Preventive medicine professionals' support for creating a number of specialist health professionals in the field of health education and carrying out a significant proportion of education & training in the medical & health schools in the primary health care services is higher than is that of curative medicine professionals.

Health Promoting Hospitals Declaration and Baby Friendly Hospitals Initiative are illustrative international examples directed towards improving health promotion practices in health and medical care. The notion of health promoting hospital provides an appropriate context within which effective education can take place. The constituent elements have been identified (WHO, 1991) as the:

- creation of a healthy environment for staff and clients;
- integration of health promotion into all the activities of institution;



- creation of healthy alliances between the hospital and other institutions resulting in a health promoting community, in which all institutions are health promoting.



**CHAPTER NINE:**  
**CONCLUSIONS AND FURTHER**  
**RECOMMENDATIONS**



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## **CHAPTER NINE**

### **CONCLUSIONS AND FURTHER RECOMMENDATIONS**

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#### **9.1 Conclusions**

The national health education programmes are regarded by health promotion officials, in general, to be good and effective. Both the officials and the public see these programmes as playing a role in the protection and promotion of the Libyan community's health.

The health officials assessed the national programme of immunisation to lead the health promotion programmes in the country, attributing its success to the positive role of health education programmes. Promotion of breast-feeding ranked second, the diarrhoea control programme ranked third, AIDS prevention fourth, and smoking prevention fifth in attributing their success to the health education programmes.

The general public participants acknowledged TV as the most effective existing health education medium in raising health knowledge, and the second ranking influencing factor to practice healthy behaviours, placing family influence at first. They valued TV spots over the regular programs. Books, magazines, and newspapers, as well as school health education, were regarded by them as important educational media both in increasing health awareness and improving behaviours. The participants considered radio to come below school health education in both respects.

The importance of health professionals as a source of health knowledge and in improving healthy life-styles is seen to be comparatively low. Posters are seen as of even lower importance. Lectures, symposia and mosques are seen at the same level of influence as posters. Leaflets and booklets are considered to be the least efficient health education media.



Officials' assessments of the existing health education media confront the public evaluations only to some extent. The officials considered TV as the most potent one, and regarded health professionals' role as a less efficient health educational medium. They assessed the efficiency of the presented health education media according to the following sequence: TV programmes; TV spots; radio programmes; radio spots; posters and mosques; lectures and symposia; health professionals; booklets, magazines, newspapers and leaflets; school health education.

The ten priority health issues, indicated by the health officials, for future health education in Libya are: Personal Hygiene, Sanitation & Environmental Health; Immunisation; Healthy Food & Proper Nutrition; Child Health; Maternal Health; AIDS Control; Accident Prevention; Child Health During School Age/School Health; Breast-feeding; and Drug Abuse Control.

The general public ranked the ten priority health issues as follows: Drug Abuse Control; Personal Hygiene, Sanitation & Environmental Health; AIDS Control; Regular Medical Check-up; Healthy Food & Proper Nutrition; Child Health; Safe Use of Medications; Sport & Physical Exercise; Immunisation; and Breast-feeding.

This reveals the need for reorientation of health promotion programmes in Libya, and the role of health education within these programmes according to future priorities.

It has been suggested to target a number of specific groups according the addressed health issues.

Health education is recommended to be strengthened as early in life as possible targeting children and youth. This is to reduce individual exposure to self-imposed risks such as smoking, drug abuse, accidents and AIDS, and to raise awareness of the importance of personal hygiene, sanitation & environmental health; healthy food & proper nutrition; and regular medical check-up. School



setting is seen as the most appropriate medium for communicating with children. Youth and sport clubs are also recommended settings in mediating health education to the youth.

Despite the acknowledgement of TV as the most effective existing health education medium in Libya, it is preferred to be utilised within future programmes, to target most of the groups and to address most of the health issues.

Combining media is recommended in several cases. TV and school health education are suggested to be employed for reaching children.

These results suggest the need for reorganising the use of different health education media in future planning, placing an emphasis on TV techniques.

Officials' assessments differ from those of the general public. These findings suggest the need for a systematic consultation across professional and lay groups as a requisite preliminary for statutory health education/promotion initiatives. Involving people in determining their own needs, will certainly reflect an increased effectiveness and efficiency.

Health professionals participated in this research perceive that they are responsible for mediating health education and see this role as important. However, less than half of them consider the existing role of health professionals in health education in Libya as very effective or effective.

The main barriers to health professionals' role in health education are: the lack of educational aids & materials; the low priority held for health education in health services & by policy makers; the lack of rooms & related facilities for conducting group health education in the health services; the lack of communication skills among health professionals; and the negative influence of factors such as family, commercial advertising, culture & traditional beliefs, on health education.



Providing educational aids & materials; improving support of policy makers; enhancing the role of mobile health education groups; and providing the different health professionals with continuing education on techniques of health education are seen the most important solutions for improving the service.

## **9.2 Further Recommendations**

Apart from conclusions and recommendations obtained from this research work, based on personal experience, the author presents the following recommendations for improving health education and promotion programmes in the country.

Health education has come a long way and it should, like any other initiative in the field, be made responsive to changes in the health environment. Since health education is a growing profession, its functions will continue to change from time to time because that is the only way to meet changes and population needs.

A speedy upgrading of the health education service to a specialist stage is needed, together with further training, support and reorientation of health professionals at district and peripheral levels.

The National Programme of Health Education is required to make accurate assessments of population needs, to develop suitable materials for health education to train other workers, including voluntary health workers, and to assist in evaluating local health education programmes.

Evaluation, should constitute an integral part of health education activities from its initial planning and throughout its implementation.

The content of the health education programme should be determined by the needs of the target groups. In order to ensure that the material is relevant, information is required about the current knowledge, attitudes and behaviour of



the population. An educational programme can then be designed to bring about the desired changes.

One-way communication is designed for the average consumer and is not always suitable for everybody. This problem may be overcome by pre-testing health education materials on a small scale before they are widely distributed. In this way, the material could be modified to make the message clearer.

In general, the mass media are best used for conveying simple rather than complex messages, and to be a part of an overall strategy, which includes face to face health education when and wherever it is possible, by transferring health education programmes from national level to sub-national levels.

Health education and promotion is too big a job for the General Secretariat of Health and Social Welfare alone to channel all needs and to meet all aspirations. Encouraging collaboration and co-operation towards expanding partnerships for health is essential.

Enhancing the role of related authorities and agencies in promoting the health of the Libyan community and making it a higher public priority, and working together in collaborative partnerships, widen availability of health education and promotion in the country, and help it to become more effective.

A number of popular and NGOs in the country should be encouraged to be equal partners in achieving health goals, and in fostering good working relationships. Activities in this direction include convening meetings of concerned persons, establishing joint committees, publishing and distributing periodicals and newsletters, organising joint programmes and field activities, sharing experiences and providing information.

Forging links among the different authorities and agencies all over the state serves several purposes: recognition and support for each authority or agency's work, exchange of experiences, sharing of methodology and materials,



and facilitation of joint actions for health. These actions are crucial for creating supportive environment and building healthy public policy.

Health promotion is in the business of influencing policies and practices which affect health. Therefore, the General Secretariat of Health and Social Welfare, together with the related authorities and agencies, should play a large role in making new policies and developing the existing ones. Examples include those to prevent child accidents, to protect the health of food consumers, to promote occupational health, to guard the community from AIDS, to support breast feeding, to enhance the role of health professionals in promoting community health and to join the global movement towards the new "health promoting hospitals".

Action has to be taken to put into effect the Resolution of The General Secretary of no-smoking work-places, cinemas and theatres, public transport, and schools, and in implementing The General Secretariat of Health Resolution on no-smoking health services, as well as, in improving the implementation of the Environment Protection Statute .

Media interest in health issues needs to be stimulated, and media promotion of health action should be facilitated and supported. The media should be given orientation training on health issues, regular press conferences should be arranged, press releases sent out and information supplied for reports and broadcasts. Media editors are to be asked to make a long term commitment to communicate vital health promotion messages to their readers, listeners, and viewers.

Moreover, the author suggests the need for further action to improve the role of the mosque and religious teachers in health education, as a relatively large number of people attend the mosque's lessons, particularly Friday sermons.

Institutions doing teaching and research can be encouraged to focus on priority health issues. Orientation and continuing education courses for health



professionals and decision-makers can keep them all together abreast of current developments.

The great medical challenges of the next few years in Libya are to find out why we have our “modern diseases”, such as, cardiovascular diseases and cancer, and how much they are due to the way we live and the environment we are creating around us.



**CHAPTER TEN**

**REFERENCES AND**

**BIBLIOGRAPHY**



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## **CHAPTER TEN**

### **REFERENCES AND BIBLIOGRAPHY**

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# **CHAPTER ELEVEN:**

## **APPENDICES**



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## CHAPTER ELEVEN

### APPENDICES:

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#### 11.1 Appendix A: First Questionnaire

**Subject: A Questionnaire to the Health Officials to Evaluate the Existing Health Education Programmes in Libya**

- Name: *(you may omit this if you choose)* .....
- Current occupation .....
- Leading qualification .....

**In questions 1, 2, 3 and 4: Tick ☒ in front of the answer you choose:**

1- How would you evaluate the present national programmes of health education?

- |                                    |                                    |                               |
|------------------------------------|------------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Very good | <input type="checkbox"/> Good |
| <input type="checkbox"/> Average   | <input type="checkbox"/> Poor      |                               |

2- Do you think that these programmes play a role in protecting and promoting the health of the Libyan community?

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

3- What is your estimation of their impact on the Libyan community?

- |   |  |                                    |
|---|--|------------------------------------|
| <input type="checkbox"/> Highly effective | <input type="checkbox"/> Effective to certain extent | <input type="checkbox"/> Effective |
| <input type="checkbox"/> Not effective    | <input type="checkbox"/> Not sure                    |                                    |

4- Is it effective on specific groups? ☐ Yes ☐ No

If yes, they are: .....

.....

5- Place in a rank order the following programmes according to the positive role of health education within these programmes: *(no. 1 for the most successful programme due to the health education intervention, no. 2 for the next ...and so on, until no. 10 for the programme which health education has the least role, in your opinion)*

- |  |   |
|--|---|
| <input type="checkbox"/> Immunisation programme                | <input type="checkbox"/> Control of diarrhoeal diseases |
| <input type="checkbox"/> AIDS prevention                       | <input type="checkbox"/> Smoking prevention             |
| <input type="checkbox"/> Breast-feeding                        | <input type="checkbox"/> Accidents prevention           |
| <input type="checkbox"/> Safe use of pharmaceuticals           | <input type="checkbox"/> Oral health                    |
| <input type="checkbox"/> Prevention of cardiovascular diseases | <input type="checkbox"/> Physical Exercise              |



6- Place in rank order the following educational media according to their efficiency in the promotion of health within the Libyan community (with your remarks on each if any): *(no. 1 for the most efficient medium, no. 2 for the next.. until no 10 for the least efficient medium). ...*

- ( ) TV spots .....
- ( ) TV programmes .....
- ( ) Radio spots .....
- ( ) Radio programmes .....
- ( ) Magazines and newspapers.....
- ( ) Booklets and leaflets .....
- ( ) Posters .....
- ( ) Lectures, symposia & mosque.....
- ( ) School health education .....
- ( ) Health professionals .....

Others you may suggest;

- ( ) .....
- ( ) .....

7- What is/are your comment(s) on the existing health education programmes in general, and your suggestions and recommendation(s) for improving the current situation (if any)?

.....

.....

.....



## 11.2 Appendix B: Second Questionnaire

### Subject: A Questionnaire to the General Public to Evaluate the Existing Health Education Programmes in Libya

- Gender:      Male(   )      Female(   )

- Age:    (   ) years

- Level of study:.....

- Occupation:.....

**In questions 1, 2, 3: Tick ☒ against the chosen answer, and you can chose more than one answer;**

1- Which of the following health issues you are familiar with?

- 1- Importance of hygiene for the prevention of diseases.(   )
- 2- Tooth care and oral health.(   )
- 3- Prevention of cardiovascular diseases.(   )
- 4- Role of physical exercise in health protection.(   )
- 5- Adverse effects of miss-use of pharmaceuticals.(   )
- 6- Harmful effects of smoking.(   )
- 7- Significance of vaccination.(   )
- 8- Following of safety rules for the prevention of accidents.(   )
- 9- Regular medical check-up role in the prevention of diseases.(   )
- 10- Importance of Oral Rehydration Therapy use to protect children with diarrhoea from dehydration.(   )

2- Which of the following healthy behaviour do you practice?

- 1- Taking care of personal hygiene.(   )
- 2- Regular use of tooth paste and brush.(   )
- 3- Eating a healthy diet.(   )
- 4- Practising regular exercise.(   )
- 5- Proper use of pharmaceuticals.(   )
- 6- No smoking.(   )
- 7- Follow-up of vaccination programme.(   )
- 8- Regular medical check-up.(   )
- 9- Following road safety rules.(   )
- 10- Using ORT in cases of child diarrhoea within the family.(   )

3- Do you think that health education programmes in Libya had any effect on promoting health?

Yes(   )

No (   )



**4- Place in rank order the following educational media, according to your perception of their effectiveness in raising health knowledge (no. 1 for the most efficient medium, no.2 for the next ..and so on, until no. 10 for the least efficient one)**

TV spots ( )  
 TV programmes ( )  
 Radio spots ( )  
 Radio programmes ( )  
 Books/Magazines/Newspapers ( )  
 Leaflets and booklets ( )  
 Posters ( )  
 Face to face education by health professionals ( )  
 Lectures/Symposia/Mosque  
 School health education ( )

**5- Who/what influenced you to adopt these healthy behaviours?**

Family ( )	Friends ( )	Peers & Colleagues ( )
Reading books ( )	Magazines ( )	Newspapers ( )
Radio ( )	TV ( )	School curricula ( )
Posters ( )		Booklets & leaflets ( )
Lectures/symposia/mosque ( )		Doctors & health professionals ( )



### 11.3 Appendix C: Third Questionnaire

**Subject: A Questionnaire to Develop an Understanding of the Health Officials for the General Public's Needs in Future Health Education Planning in Libya**

#### Part I: Personal Data:

- Name: *(optional)*: .....
- Gender:                      Male ( )                      Female ( )
- Leading qualification:  
Intermediate Diploma ( )    BSc or equivalent ( )    MSc or equivalent ( )    PhD or equivalent ( )
- Current Occupation: .....

#### Part II: Questions:

- 1- Please indicate five (5) priority health issues you consider should be addressed, towards the general public, by future programmes of health education in Libya.
- 2- Kindly suggest group(s) of people you see as most important to be targeted for each single health issue.
- 3- Also, please select the educational medium/media you perceive as more effective & suitable for each group, with respect to the indicated issue.

■ *(You may indicate the same group for more than one health issue. You can, as well, select the same educational medium to be used for different issues or groups)*

#### Examples of Health issues:

Child Health, Maternal Health, Child Health During School Age (School Health), Immunisation, Personal Hygiene & Environmental Health, Control of Diarrhoeal Diseases, Breast-feeding, Family Planing, Teeth & Oral Health, Regular Medical Check-up, AIDS Control, Healthy Food & Proper Nutrition, Physical Exercise & Sport, Cardiovascular Diseases Prevention, Diabetes Control, Cancer Prevention, Safe Use of Medications, First Aid, Accidents Prevention, Psychiatric & Mental Health, Prevention of Acute Respiratory Infections, Tuberculosis Prevention, Eye Diseases & Blindness Prevention, Drug Abuse Prevention, Alcohol Drinking Prevention, Occupational Health,...

#### Examples of Targeted Groups:

Parents, Patrons, Mothers, Women, Youth, Female Youth, School Children, Under 6 Children, Visitors to Health Services, Elderly People, Patients with Chronic Disease, Diabetics, Handicapped/Disabled People, Smokers, Industrial Workers/Labour, Military Personnel, ....

#### Examples of Educational Media:

TV Programmes or Spots, Radio Programmes or Spots, Books, Booklets, Leaflets, Newspapers, Magazines, Posters, Internet, Nursery Schools, Primary/Preparatory/Secondary Schools, Universities, Youth Clubs, Scout/Red Crescent Groups, Health Professionals (Physicians, Nurses & Related Professionals), Social Workers, School Teachers, Theatres, Cinemas, Lectures, Symposia, Seminars, School Curricula, School activities, Home Visits, Mobile Educational Teams, Mosques, Beach Clubs, Military Bases/Camps, Factories,...



**Explanatory example:**

<b>Indicated Health Issue</b>	<b>Suggested Targeted Group(s)</b>	<b>Recommended Educational Medium/Media</b>
Smoking Prevention	School Children	School Curricula
		TV spots & Programmes
	Youth	Parents
		TV
		Youth & Sport clubs
		Printed materials
	Adult Smokers	TV & Radio
		Health professionals
		Mosques

*(This is only an example. The above mentioned health issue, targeted groups & educational media will not be considered as a part of your answers. If you agree on any of them you need to write it/them again)*

<b>Health Issue</b>	<b>Suggested Targeted Group(s)</b>	<b>Recommended Educational Medium/Media</b>
<b>(1)</b> _____	_____	_____
		_____
		_____
	_____	_____
		_____
		_____
	_____	_____
		_____
		_____
	_____	_____
		_____
		_____







[illegible]

(5)

[illegible]

**Suggestions and/or recommendations of needs for future health education programmes (if any):**

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## 11.4 Appendix D: Fourth Questionnaire

**Subject: A Questionnaire to Develop an Understanding of the General Public for their Needs in Future Health Education Planning in Libya**

### Part I: Personal Data:

- Name: *(optional)*: .....
- Age: 20yrs or below ( )    21-30yrs ( )    31-40yrs ( )    41yrs or over ( )
- Gender:                      Male ( )                      Female ( )
- Level of education:  
Primary School or lower ( )    Secondary School or equivalent ( )    University Degree or higher ( )
- Occupation: .....

### Part II: Questions:

- 1- Please indicate five (5) priority health issues you consider should be addressed, towards the general public, by future programmes of health education in Libya.
- 2- Kindly suggest group(s) of people you see as most important to be targeted for each single health issue.
- 3- Also, please select the educational medium/media you perceive as more effective & suitable for each group, with respect to the indicated issue.

■ *(You may indicate the same group for more than one health issue. You can, as well, select the same educational medium to be used for different issues or groups)*

#### Examples of Health issues:

Child Health, Maternal Health, Child Health During School Age (School Health), Immunisation, Personal Hygiene & Environmental Health, Control of Diarrhoeal Diseases, Breast-feeding, Family Planning, Teeth & Oral Health, Regular Medical Check-up, AIDS Control, Healthy Food & Proper Nutrition, Physical Exercise & Sport, Cardiovascular Diseases Prevention, Diabetes Control, Cancer Prevention, Safe Use of Medications, First Aid, Accidents Prevention, Psychiatric & Mental Health, Prevention of Acute Respiratory Infections, Tuberculosis Prevention, Eye Diseases & Blindness Prevention, Drug Abuse Prevention, Alcohol Drinking Prevention, Occupational Health,...

#### Examples of Targeted Groups:

Parents, Patrons, Mothers, Women, Youth, Female Youth, School Children, Under 6 Children, Visitors to Health Services, Elderly People, Patients with Chronic Disease, Diabetics, Handicapped/Disabled People, Smokers, Industrial Workers/Labour, Military Personnel, ....

#### Examples of Educational Media:

TV Programmes or Spots, Radio Programmes or Spots, Books, Booklets, Leaflets, Newspapers, Magazines, Posters, Internet, Nursery Schools, Primary/Preparatory/Secondary Schools, Universities, Youth Clubs, Scout/Red Crescent Groups, Health Professionals (Physicians, Nurses & Related Professionals), Social Workers, School Teachers, Theatres, Cinemas, Lectures, Symposia, Seminars, School Curricula, School activities, Home Visits, Mobile Educational Teams, Mosques, Beach Clubs, Military Bases/Camps, Factories,...











(4)

(5)

**Suggestions and/or recommendations of needs for future health education programmes (if any):**

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## 11.5 Appendix E: Fifth Questionnaire

**Subject: A Questionnaire for Health Professionals to Improve Health Education Services in Libya**

-Name: *(You may omit this if you choose)* \_\_\_\_\_

- Please tick ☒ only in the appropriate box.

☐ **Personal data:**

-Gender: ☐ Male ☐ Female

-Profession:

- ☐ Physician, speciality, if applicable: \_\_\_\_\_ ☐ Dentist
- ☐ Pharmacist ☐ Nurse ☐ Midwife ☐ Health visitor
- ☐ Dietician ☐ Community health technician ☐ Health administrator
- ☐ Another. Please specify: \_\_\_\_\_

-Qualification:

- ☐ PhD or equivalent ☐ MSc or equivalent
- ☐ BSc or equivalent ☐ Intermediate Diploma
- ☐ Secondary school ☐ Primary school or lower.

-Field of work:

- ☐ Curative medicine ☐ Preventive medicine ☐ Another. Specify: \_\_\_\_\_

☐ **Questions:**

**1- In your view, do health professionals should have a responsibility for health education?**

- ☐ Yes, it is an integral part of health professionals' role.
- ☐ A limited responsibility.
- ☐ Only the responsibility of health professionals working in the preventive services.
- ☐ Only for "at risk groups".
- ☐ No, it is not their responsibility at all.
- ☐ Uncertain.

**2- How do you consider the importance of health education by health professionals?**

- ☐ Very important ☐ Important ☐ Of little importance
- ☐ Not important ☐ Uncertain.

**3- How do you assess the effectiveness of the existing role of health professionals in health education in Libya?**

- ☐ Very important ☐ Important ☐ Of little importance
- ☐ Not important ☐ Uncertain.



4- Please tick ☒ only in front the degree of agreement you perceive with respect to each of the following barriers for delivering effective health education by health professionals:

1- Not enough time to practice health education.

☐ *Strongly agree*    ☐ *Agree*    ☐ *Uncertain*    ☐ *Disagree*    ☐ *Strongly disagree*

2- Health professionals lack communication skills.

☐ *Strongly agree*    ☐ *Agree*    ☐ *Uncertain*    ☐ *Disagree*    ☐ *Strongly disagree*

3- Education & training of health professionals are carried out at the curative medicine services (Little knowledge of health education).

☐ *Strongly agree*    ☐ *Agree*    ☐ *Uncertain*    ☐ *Disagree*    ☐ *Strongly disagree*

4- The language health professionals use is difficult to understand.

☐ *Strongly agree*    ☐ *Agree*    ☐ *Uncertain*    ☐ *Disagree*    ☐ *Strongly disagree*

5- Health education is held to be of lower priority than is curative medicine in health services and by policy makers.

☐ *Strongly agree*    ☐ *Agree*    ☐ *Uncertain*    ☐ *Disagree*    ☐ *Strongly disagree*

6- Some professionals see health education as too trivial a job for them to do, or as merely the job of those working in the preventive health services.

☐ *Strongly agree*    ☐ *Agree*    ☐ *Uncertain*    ☐ *Disagree*    ☐ *Strongly disagree*

7- There is a lack of educational aids & materials.

☐ *Strongly agree*    ☐ *Agree*    ☐ *Uncertain*    ☐ *Disagree*    ☐ *Strongly disagree*

8- Health services lack rooms & related facilities for conducting group health education at the health services.

☐ *Strongly agree*    ☐ *Agree*    ☐ *Uncertain*    ☐ *Disagree*    ☐ *Strongly disagree*

9- Factors such as family, commercial advertising, culture & traditional beliefs have a negative influence on health education.

☐ *Strongly agree*    ☐ *Agree*    ☐ *Uncertain*    ☐ *Disagree*    ☐ *Strongly disagree*

10- Health education is of no or little interest to the recipient.

☐ *Strongly agree*    ☐ *Agree*    ☐ *Uncertain*    ☐ *Disagree*    ☐ *Strongly disagree*

11- Some professionals fear upsetting people.

☐ *Strongly agree*    ☐ *Agree*    ☐ *Uncertain*    ☐ *Disagree*    ☐ *Strongly disagree*

12- The presence of other people at the same place (e.g. the pharmacy) hinders discussions on private matters.

☐ *Strongly agree*    ☐ *Agree*    ☐ *Uncertain*    ☐ *Disagree*    ☐ *Strongly disagree*

13- Health professionals are not invited to participate at the community activities.

☐ *Strongly agree*    ☐ *Agree*    ☐ *Uncertain*    ☐ *Disagree*    ☐ *Strongly disagree*



14- Some health professionals are not interested in cooperating & participating in community activities.

- ☐ *Strongly agree*
- ☐ *Agree*
- ☐ *Uncertain*
- ☐ *Disagree*
- ☐ *Strongly disagree*

15- There is information contradiction between different professionals.

- ☐ *Strongly agree*
- ☐ *Agree*
- ☐ *Uncertain*
- ☐ *Disagree*
- ☐ *Strongly disagree*

Others you may suggest:

5- Please tick ☒only in front to indicate of the degree of agreement you perceive with respect to each of the following suggested solutions for improving health professionals' health education:

1- A signification proportion of education & training in the medical & health schools should be based in the primary health care services.

- ☐ *Strongly agree*
- ☐ *Agree*
- ☐ *Uncertain*
- ☐ *Disagree*
- ☐ *Strongly disagree*

2- Communication skills should be included within the teaching programmes for medical & health sciences students.

- ☐ *Strongly agree*
- ☐ *Agree*
- ☐ *Uncertain*
- ☐ *Disagree*
- ☐ *Strongly disagree*

3- Continuing education on techniques of health education should be provided for the different health professionals.

- ☐ *Strongly agree*
- ☐ *Agree*
- ☐ *Uncertain*
- ☐ *Disagree*
- ☐ *Strongly disagree*

4- A number of health professionals should be specialised in the field of health education.

- ☐ *Strongly agree*
- ☐ *Agree*
- ☐ *Uncertain*
- ☐ *Disagree*
- ☐ *Strongly disagree*

5- Health professionals should be provided with educational aids & materials.

- ☐ *Strongly agree*
- ☐ *Agree*
- ☐ *Uncertain*
- ☐ *Disagree*
- ☐ *Strongly disagree*

6- Provision of suitable rooms & related facilities for conducting group health education should be facilitated.

- ☐ *Strongly agree*
- ☐ *Agree*
- ☐ *Uncertain*
- ☐ *Disagree*
- ☐ *Strongly disagree*

7- Support of policy makers needs to be improved.

- ☐ *Strongly agree*
- ☐ *Agree*
- ☐ *Uncertain*
- ☐ *Disagree*
- ☐ *Strongly disagree*

8- Enhancing the role of mobile health education groups is important.

- ☐ *Strongly agree*
- ☐ *Agree*
- ☐ *Uncertain*
- ☐ *Disagree*
- ☐ *Strongly disagree*

Others you may suggest: