

## HEALTH EDUCATION\*

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THE opportunity to make a start in health education presented itself when I arrived in Nigeria during a very serious outbreak of plague. Before I had time to unpack my boxes, I was handed a hypodermic syringe and many bottles of anti-plague vaccine and told to go off into the native city of Lagos and inoculate as many people as possible. With the help of numerous policemen, I managed to inoculate over 600 extremely noisy people the first day and thought I had done well. I resumed operations the following morning, but found I was forcibly inoculating people more than once and so we started issuing slips of paper with the office rubber stamp and date. However, many young Africans were still presenting themselves for inoculation a second time, and we then discovered that they were selling the slips of paper to those who wished to avoid inoculation.

Another anti-plague measure was the establishment of rat-buying stations, where the Government paid 2d. for each dead rat handed in. Imagine my surprise when one African, who honestly thought he was aiding the cause, came along with nearly 100 live rats feeling quite proud of the fact that he had bred them himself.

As fast as plague gangs baited traps, householders flung them into the street. Bodies of plague victims were dumped in dark corners or thrown into lagoons with no hope of tracing contacts, and wide confusion existed. Feeling very depressed about it all, I saw the Chief Secretary and told him something must be done to explain to the people how plague was spread, why it was essential to reduce the rat population, and the reason why inoculation, isolation of contacts and other preventive measures were necessary. He readily agreed and suggested I should do something about it, which I did, and never was time better rewarded. I recruited an enthusiastic team of Africans and then, using exhibits, films, film-strips, wall stencil posters and other visual aids, the life history of plague, and the reasons *why*, as well as *how*, were clearly explained. Slowly but surely the people began to understand. They responded well and, with their full co-operation, plague was completely wiped out.

With the plague scare over, I was encouraged to extend health education to all parts of Nigeria, a country four times the size of England and with a population of over 25 million unenlightened people. I soon realized the magnitude of the task I had taken on, not so much from the size and population of the country, but from the difficulty of finding ways and means of persuading people to play their part and do things for themselves. Little difficulty was experienced in arousing interest, but how to get below the surface and satisfy that interest to a point where the people were prepared to take some action was a difficult problem to solve.

In Lagos, interest in the prevention of plague had been keen because the real danger to life was on everyone's doorstep. Under more normal conditions the public reaction to the prevention of tuberculosis, for example, was that they as individuals failed to identify themselves with the disease, and did nothing, although they understood how the disease was spread. Talking to the people about the prevention of any particular disease appeared to be a waste of time.

With more experience the approach was changed, and all preventable diseases were grouped in relation to where they began: *excreta-borne*, *water-borne*, *insect-borne* and *air-borne*. By concentrating on each of the four groups in turn, it was possible to suggest measures the people might take to prevent, not just one disease but a whole host of diseases. This approach appeared more promising and it was encouraging to return to an area and find some of the people putting into practice the simple measures previously suggested. Later, however, I was very disappointed to find it was only a matter of time before those few converts had left off the new practices and drifted back into their old traditional habits; the reason for this was not far to seek. I had not succeeded because I found the greatest difficulty in dissociating any health problem from its context with my own life and background, as I tried to see it in the new environment

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in which I was attempting to plant it. Slowly I learned to understand and respect the reasons why certain local practices followed their own traditional way of life. Many practices relating to health and disease are sanctioned by mythology and reinforced by ritual, which in themselves offer the greatest resistance to change unless such changes can be made to fit into the matrix of local culture. Only by working upon established interest, by showing the people how to adapt the rules and conventions which surrounded them could we make any headway in guiding people in their search for better health, better homes, and better living. All suggestions for improvements and the methods employed in introducing them were based on careful investigation and from that time health education went ahead and proved popular in all parts of Nigeria.

Quite a number of major improvements for raising the standard of public and domestic sanitation were accepted by the majority of the community and it is gratifying to be able to say that over the years many of them have been grafted on to the traditional way of life and are in regular use to-day. There is not sufficient time to go into detail with regard to the methods and techniques used, but I would like to stress the tremendous advantages of using visual aids with all types of audiences, young and old, literate and illiterate alike.

Something which is seen is always more convincing than something which is heard. Quite often what is said at a lecture or discussion is forgotten almost as soon as it ends and, unless some unusual or sensational point has been raised, the whole effect is largely wasted. By introducing visual aids, the mind has far greater power to retain the idea or message involved. Films, filmstrips, posters, flannelgraphs, wall charts, pamphlets and booklets are among the visual aids in general use, but no list of visual media is ever complete, because anything which can be seen and handled in association with speech is a visual aid. Perhaps the most effective, cheapest (and most neglected) of all visual aids is the flannelgraph, which seems to be capable of fixing a message or idea permanently in the minds of audiences of all ages. It has animation and colour; audience participation can be introduced and, in fact, it has everything to recommend it.

Visual aids help considerably in speeding up the process of communicating a message or idea and so in this age of speed, when time is short and the message vital, it is not surprising to find that more and more health workers are beginning to look upon visual aids as being essential tools of their calling.

Films are perhaps the most spectacular of all visual media. They can be entertaining and informative and leave a lasting impression on the minds of people of all ages. Full-scale feature narrative films, with all the ingredients essential to be good "box office" are very costly and are usually produced commercially on a national basis. On the other hand, there is no reason why anyone with some knowledge of photography should not attempt the production of short films which include local places and faces, and which call for little knowledge of the more involved techniques of film-making. I was very surprised, on returning to this country, to find that more use is not being made of locally-produced films by health departments here at home, and I feel sure that if medical officers of health knew how easily, how inexpensively, and above all how effectively, simple films can be made by almost any member of their staff, it would not be long before local health department activities were reproduced on the screen. A start could possibly be made by the Central Council for Health Education acquiring suitable 16 mm. camera equipment and making it available to those who would like to try out the idea. With a good camera, loaded with modern film stock, good photographic quality can be assured right from the start. Having filmed a subject, however, it is preferable for the exposed material to be handed over to experts for finishing. Editing and titling can be carried out commercially quite cheaply by technicians specializing in this kind of work. The cost of suitable film stock is 27s. 11d. per 100 ft. inclusive of processing. The finalizing of films, if done commercially, would cost another £4, so that the total cost of a film of four minutes' screen time would be less than £6 10s.

I think such an experiment would be well worth while and I have not the least doubt that once you have experienced local reaction and the effectiveness of including familiar faces in your usual film programmes, you will wish to continue doing so for all time.