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Populations living in poverty and with low education: How health education programs can make a difference

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Abstract

This contribution describes the approach taken by IMIFAP, a Mexican NGO, to the development and administration of programs that target health behaviour changes in communities and schools. In twenty years time our programs and books have reached over 17 million people in 14 Latin American countries, often living in rural areas with inadequate schools and virtually always in poverty. The IMIFAP approach seeks to combine the needs expressed by program clients, a theoretical basis from the development and psychology literatures, and empirical research. Programs focus on bringing about behaviour change by enabling skills, increasing knowledge and reducing psychological barriers. Such programs have been demonstrated to lead to an increase of behavioural choices in concrete situations that have been program targets and from there to broader changes such as more personal agency and agentic empowerment. This in turn impacts on the social and structural context in which individuals live. One of the programs is presented as an illustration. Lastly, the means through which Psychology can make an economic perspective such as that of Amartya Sen is briefly described.

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" ... we are very, very poor, most of us only read a little and do not write, many do not speak Spanish, only Mixteco, and so it easier for the politicians to take advantage".

".... People come here all the time to bring programs…they talk and talk and we just sit there; they think we understand and go away after a few hours very pleased".

"... They say that if we have a test we can prevent cancer, but cancer comes from the air that we breathe when it is not good, so how can a test where they see our [private] parts help?"

"... They tell us to go for vaccines and check ups of women's things, that they will make sure a doctor will be at the clinic a certain day, but we don't even know if the bus will come by that day".

".... I feel ashamed of going to a doctor. What will he think! He knows much more than I do".

"... It is not so easy just to tell our husbands that we want to go to the doctor, they would not let us, they would be suspicious: why a doctor if you are not sick, he will see your parts and maybe touch you. We cannot do that; we may even get a beating".

"We are not supposed to go to work. People will talk. Women are supposed to stay home."

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These comments are from rural Mexican women. They have been placed here to focus the reader's attention on the powerlessness of people in poverty and illiteracy. They also can be used to exemplify the principles that underlie the IMIFAP approach to developing and implementing health behaviour promotion programs. Let us briefly look at some of these.

"They think we understand and go away after a few hours, very pleased"

Good Samaritans or health specialists developing and implementing a health education program without first determining people's needs and interests greatly reduce the probability of acceptance and, as a consequence, the adoption of the suggested behaviour changes. The first principle is that programs have to be driven by the needs of the intended program clients and by their own understanding of these needs (Givaudan, Pick, Poortinga, Fuertes & Gold, 2005; Pick and Poortinga, 2005).

"We are very, very poor...we may even get a beating"

A second principle is that changes in health behaviour have to take into account the structural context, i.e. the educational, political, economic and ecological conditions in which people live, as well as their social norms and expectations The context we live in imposes constraints on the resources available for addressing local issues and problems, both economically and psychologically (Berry, Poortinga, Segall, & Dasen, 2002). Still, virtually any context also comes with opportunities or affordances, and programs have to enable or facilitate these. In communities with low education and low affluence, obedience is much more socially accepted than informed decision making (Weiner-Levi, 2006). Among other things this has led to gender roles in which women are expected to follow what the men say rather closely (Amuchástegui, 2001).

A corollary of this second principle is a program has to be promoted. With each major program there has to be a range of activities aimed at advocacy and dissemination, not only among program clients to make them participate, but also among administrative authorities and other stakeholders, including teachers, staff of rural clinics and, in the case of programs for women, the men.

"... cancer comes from the air"
"... I feel ashamed"

The third principle that IMIFAP follows may be less self-evident. Our programs are meant to bring about changes in characteristic situations. Many programs address psychological characteristics of the person, using instruction and explanation and promoting participation and self reflection. Our approach is to focus on concrete situations and to provide tools enabling individuals to deal effectively with situations that are difficult for them. Such tools include knowledge, skills and the reduction in psychological barriers that limit individuals the possibility of addressing these situations.

Knowledge refers to fact-based information and has to be distinguished from (non-factual) beliefs. For example, in rural Mexico the belief can be found that the use of contraceptives will lead to the piling up of babies in the abdomen, or that water should not be boiled because that reduces its vitamin content. Although providing factual information is an essential component of any program, it is important to note that offering information on its own often fails to create positive change (Fishbein & Guinan, 1996). Programs with one-sided emphasis on knowledge do little to change attitudes, beliefs, let alone concrete actions (Smith, Zhang, & Colwell, 1996; Uchoa et al., 2000).

Skills including decision-making and communication provide program participants with the tools to translate information into action. The mode of program implementation should be interactive rather than instructional. The group setting of workshops facilitates receiving social support, or as one young woman put it: "getting permission to make choices and do things that are not accepted by the community but that are necessary for us to have better lives".

Psychological barriers such as shame, guilt and fear act in ways that paralyze action. They are a result of social pressures and the internalization of educational means (threats, fear) and messages of key socializing agents that lead to mainly an external source of control rather than inner regulation of one's decisions and choices of action. Through sharing, discussions and role playing more agentic forms of behaviour can be acted out in the protected setting of a workshop.

Moreover, "The Life Skills" approach has become a prominent international strategy, (Pick, Givaudan, & Poortinga, 2003; World Health Organization [WHO], 1999). The WHO emphasizes that key elements of a life skills program include: skills development; informational content addressing relevant social and developmental tasks, and interactive methods of teaching and learning (Mangrulkar, Whitman, & Posner, 2001). Developing the use of appropriate skills

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and integrating them with knowledge and clarification of beliefs allows the individual to develop competencies which enable them to react optimally according to his or her own standards and desired outcomes. These lead to behaviours, which amount to the application of being able to expand one's choices.

"I want to, I can…care for my health and exercise my rights (originally called "If I am OK, so is my family")

Social norms in rural Mexico prescribe that women put care for others before themselves. In one of the programs developed by IMIFAP the saying "If I am OK, so is my family" was used as the program's name to convey the idea that women need to be healthy if they are to look after their families. "If I am OK, so is my family" was developed for and implemented in the Mixteca, which is one of the poorest regions in Latin America and certainly in Mexico.

Based on extensive assessment of needs including interviews and focus groups with women as well as other stakeholders, six modules were developed: four for the women themselves, namely, *Health*, *Hygiene*, *Nutrition and Sexuality* and two for them to replicate with their children: *Development* and *Health*. Throughout the program a gender perspective was emphasized, together with the women's need for personal agency.

Thirty nine thousand young women (mostly 12-25 years of age), participated in 120 hours of training workshops designed to provide knowledge and promote the development of skills. The implementation of the program was realized through a closely supervised "cascade" with three levels of "replicators" who all received a special training of several days prior to each module. Twenty community action promoters employed by the federal public health sector were trained by *IMIFAP* staff. They trained 500 rural health assistants working in the local Oaxaca health system, who in turn replicated the training workshops with approximately 3,100 local volunteer community health promoters. The latter group offered weekly two-hour workshops to 39,000 women of their communities in groups of approximately ten to fifteen persons. The methodology was highly participatory, using role playing and other interactive exercises.

Extensive efforts were made towards advocacy among local politicians and health officials and towards dissemination of the program and its messages and goals among the general public (e.g., a local radio station broadcasted a health message every hour for the duration of the program implementation) to provide support for changes in socio cultural norms.

The program was monitored with both process and outcome evaluation methods. A controlled study showed significant changes in target behaviours (Pick, Venguer & Fishbein, in press). Such effects were also found again when the program was administered in Guatemala (Leenen et al., in press). The effectiveness of the program was supported by process evaluation data; perhaps the most impressive finding was that the rate of attendance was over 85% staying high throughout the program . Moreover, there were numerous testimonies that we heard from the women three years after completion of the program. When we returned to the region; many women expressed deep gratitude. They saw the program as having led them to start a business such as a bakery or taco stand, to become political active, organize women's groups, participate in the organization of community festivities previously not permitted for women, negotiate with their husbands, and a score of other activities:

A medical doctor from the region expressed the changes he had seen as follows:

"The women used to be quiet, looking down at the floor and whatever I would say they would just nod their heads to agree…whatever I would say they agreed. I have seen a great change, they look at my eyes, ask questions and even negotiate regarding when the surgery will take place or ask how long the recuperation process will take…they say "we are now empowered".

Changes towards agency and empowerment

In the course of participating in a program like "I want to, I can…care for my health and exercise my rights"people start to gain confidence in their ability to make decisions in some situations, they acquire a sense of responsibility and they start taking charge of their life. Having a sense of control over one's choices is essential for being able to form the intentions which precede behaviours. If the (lack of) perceived control over one's behaviour is seen as external (normative), the probability for choosing a course of action that one desires is strongly diminished (Pick, 2007).

Although the generalization or expansion from new reactions in a few situations to new characteristic forms of behaviour is not well understood, it is now widely accepted that such generalization does occur (Flay, 2002; Lave & Wenger, 1991). There are various concepts referring to a person's general capability to deal with difficult situations in a socially competent and confident manner, including agency (Kagitcibasi, 2005), self efficacy (Bandura, 1997), self esteem (Baumeister, 1993), self determination (Deci & Ryan,

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2000), internal locus of control (Rotter, 1966), empowerment (Stein, 1997) and autonomy (Assor, Kaplan & Roth, 2002). Agency is used as an umbrella concept to encompass these notions. Agency develops as competencies are experienced that go beyond what is directly being addressed in a program. It develops in concrete situations (e.g., going for a vaccine, having a Pap smear, talking to the school director). In its broadest sense agency leads to having control over more and more situations. In short, human agency is the recognition that people *can* be, and I would go a step beyond, *must* be agents of their own well-being. Only in this way can they be held responsible for the decisions they make regarding what behaviours they engage in.

As people realize that they can be agents of their own actions and perceive that they can have more control over their own lives, this sense of agency also allows them to become actively and constructively engaged in their social environment. We have called this agentic empowerment, i.e., an empowerment that evolves from within the person rather than from extrinsic (e.g. material or economic) or systemic (e.g. rules, norms and laws) incentives (Pick & Sirkin, in preparation). For example, a woman may start talking with her immediate and extended family and other community members about the importance of having a Pap smear (Givaudan et al., 2005) or not tolerating domestic violence (Fawcett, Heise, Isita-Espejel, & Pick, 1999).

As mentioned in the description of "I want to, I can…care for my heath and exercise my rights" we found in follow-up studies a few years after the completion of this program that as a result of participation in it, women tended to report various changes in their lives, scattered across a range of domains, but attributed by them to what they learned through the program. For example, they reported discussing more matters with their husbands, being more tolerant and even supportive of informed autonomous decision making rather than only blind obedience in their children, operating a small scale business, and negotiating with officials instead of leaving important decisions up to third parties.

Gradually such changes also will lead to changes in socio-cultural norms. Empowerment takes place when people influence or modify economic, cultural or social barriers. Agentic empowerment is both a process and a state of inner power that allows for autonomy and a sense of control over one's environment, not as an object but as a direct agent of change. Elsewhere these broader prospects have been elaborated in a framework that seeks to account for the theoretical explanation of agentic change and empowerment. Pick et al., 2003; Pick & Sirkin, in preparation).

There it is also shown how ideas about agency as found in psychology converge with recent ideas in developmental economics, especially those formulated by the Nobel Prize winning economist Amartya Sen (e.g., 1999) that are revolutionizing development policies worldwide. Programs like those of IMIFAP amount to making Sen`s theory about development operational. Psychologists have a store of theoretical and empirical knowledge that can contribute to sustainable development. Maybe we have to be less modest about what we can contribute. Like the women in the Mixteca we may have to learn: "I want to, I can".

In his well known book "Development as Freedoms" Sen (1999) defines development in terms of expanding individual freedoms. He argues that economic factors are a means to development and cannot continue to be seen as the end goal. These freedoms depend on a number of factors and can be divided into five categories: political freedoms, economic facilities, social opportunities, transparency guarantees, and protective security; Sen states, "Each of these distinct types of rights and opportunities helps to advance the general capability of a person." (1999, p. 10). In his theory capabilities refer to the freedom to achieve doing and being functionings. In FENAE terms we have translated 'doing functionings' to what a person succeeds in doing (behaviours) with the commodities and abilities given his knowledge, skills and context, while Sen's 'being functionings' we have interpreted as the personal characteristics which the individual achieves as a consequence of having tried out and succeeded in several behaviours (e.g. personal agency).

Both Sen and the IMIFAP rationale emphasize that one is able to enhance choice as one enhances one's capabilities. The context in FENAE encompasses the freedoms and entitlements (defined as the social, political and economic opportunities that are available to us and that can act to facilitate or to constrain human development (socially as well as and economically) depending on the mindset (i.e., degree of agency) of the individuals that make up its institutions and their degree of empowerment.

Conclusions

Today "If I am OK, so is my family" has reached over 300,000 Mexican women and their families. It has become part of an integral community development effort with the United Nations Foundation that, in addition to this community health program, also

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includes school based and micro enterprise development programs which follow the same approach and has changed its name to "I want to, I can…care for my health and exercise my rights". Each of several modules addresses a specific topic, for example "I want to, I can…prevent cancer", "I want to, I can…create my business, "I want to, I can… prevent alcohol abuse" and "I want to, I can… prevent violence"; see www.imifap.org.mx).

IMIFAP programs all have a common basis: they aim to enable individuals to promote their own wellbeing through the expansion of choice. This is realized through addressing concrete situations in which individuals would like to change their common, and socially approved, pattern of behaviour. A single act of a single individual is seen as the source and origin of change. Repetitions of such acts across situations lead to the development of individual agency; its impact on the context is defined as agentic empowerment. In this way health behaviour choices expand and become part of broader changes and opportunities (in Sen's terms "freedoms") in individuals and their communities.

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