Health Education Activities in a Personal, Practical Perspective

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In general, the applications of health education in Thailand have developed from efforts to solve the health problems of rural people, who have been under- served by the health services delivery system of the government. The concept of community oriented health education is a basic one and it provides the key to success of the health care program. Community self-reliance is another concept which the program seeks to foster in its many development strategies. The Thai Ministry of Public Health is continuously aware that the strengthening of the health education and the development of the referral system are essential in supporting health care activities.

Permit me now to address some examples of what health education involves from my own experiences, both past and present, in rural health care. I give these examples in order to highlight what can be achieved by making use of existing resources to turn challenges into what I can also call the social and political "opportunities" which exist in communities and which can be employed to achieve improvements in health care delivery ,and ultimately, in the people's quality of life.

Health Education Challenges : Early Experience of a Rural Doctor.

When I graduated from medical school in 1960, I returned to my own home district in Khon Kaen province, about 345 kilometers Northeast of Bangkok. I could have practiced my profession in a more affluence place like most doctors decide to do. But I told myself that if all doctors leave my district, then it will continue to be a district of disease and disillusionment. Without many of people who still live there, I would not have even had the chance to become a doctor. With that realization and the decision to stay behind, I started a long

and, sometimes, tedious journey, toward rehabilitating my district in unspoken name of primary health care.

Even before I returned home, though, I realized that I had quite a job ahead of me. The Northeast of Thailand was and still is a very deprived and poor area with a lack of adequate health facilities and resources leading to the population's poor health status. In general, the following conditions currently exist and were much worse when I first started my work:

1. ***Environmental Constraints*** – very low soil fertility; a severe lack of water (both in quantity and quality) during the dry and hot seasons (November-April); and unpredictable periodic drought versus flood conditions in the "rainy" season (May-October).
2. ***Population and Production*** – the highest population size in absolute figures, percentage-wise and density; the second largest family size; the greatest out-immigration for increased work opportunities; a labor force characterized by low levels of education; and an almost complete lack of cash, investment-power or credit-worthiness;
3. ***Health Condition*** – the largest number of malnourished children in absolute figures as well as percentage-wise; the highest incidence of diarrhea disease, particularly among children; the largest percentage of still births as well as home deliveries; the second lowest concerning infant birth-weight; the second highest regarding incidences of infections and parasitic diseases; yet, the region exhibits the highest number of Village Health Volunteers (VHVs) and Village Health Communicators (VHCs) along with the lowest population per trained medical profession (i.e. doctor, nurses, midwives).

My first day of service was not bright one; it greeted me with a poorly maintained and dilapidated building which had been staffed by various health auxiliaries, but which had no medical officer. My first "official act" as a doctor was to clean and paint the health center myself. I realized I could not hire someone else to do it for me, since I learned early on in my life and through the lives of others that people value those persons who can help themselves. More often than not, they also learn from them as well. For me to hire someone else would show my fellow community members that I was better than they were; I could afford to pay someone else to do something that I, myself, could do. But more damagingly, I would also by saying that I could not help myself; ***if he can't help himself,*** the people would think, ***then how can this young doctor help me***. Their confidence in me would be gone, as well as any chance for me to improve their confidence in themselves. From then on, aside from medical care, my main activity was mobilizing local resources for the improvement of facilities and services through the people oriented health education acitvities.

I also realized that anything done would have to be achieve without additional support from the government. Government, no matter how efficient and effective, cannot give everything to everyone's satisfaction. I educated this health problems to the people through community leaders, and I tried to convince them that improve services would be of great benefit to them. To achieve my goal, I set out to encourage every villager to contribute on bath (about 5 US cents at that time) towards the construction of a new health center. I explained to the people that the Thai government was building only 4 new health centers a year in four districts around the country. Since there were 400 districts in Kingdom, it might take 100 years before Muang Phon (my hometown) got one.

In my health education activities, local municipal councilors, village headmen, businessmen, teachers and other community leaders assisted me, and I produced a newsletter to give information about health as well as recognition to these

people. On the occasion, and again at later times, I was overwhelmed by the response. Even the very poor gave more than was requested; and amongst the wealthier community members there was a friendly competition to see who could help me most. Eventually, by mobilizing financial resources from individuals, businesses and the local government, we were able to complete a health center with an operating theater, X-ray equipment, dental clinic, living quarters, as well as a kitchen and laundry.

Health Education and Manpower Development

Staffing was another major problem I faced, and I was able to recruit and train a variety of local helpers at a low cost. In conference with the district chief, education officer, teachers and village headmen, I told them about the staff shortage and explained that it was a unique opportunity. Many young girls in the area were without employment, especially those with secondary-level education. These girls were too well-educated to work in the fields, but they were not qualified to do, for example, office work. I asked these community leaders to talk with the girls to see if they wanted to work as nursing volunteers, after receiving training, the volunteers received certificates of appreciation from the mayor and were paid five bath a day, while others were sent to provincial hospitals for further training. When they returned, they were equipped with new ideas and express more enthusiasm and willingness to work for the people. They were given valuable health information which they knew they use to help themselves and others.

Effective Communication Development

Participation by the local people, however, should involve more than financial and manpower contributions (as important as they are) in order to truly achieve self-determination and self-reliance. In 1970, the Thai Ministry of Public Health (MOPH) took over the administration and operating cost of the Muang Phon Health Center and appointed

me as the Center's Director. At that time, there was an alarming increase in the district's population growth rate(3.3 percent per year), so the MOPH requested me to develop a pilot health education for family planing program, which gave me the opportunity to further involve the people in adopting personal responsibility for their well-being.

Family planing is a very challenging area in health education and communication, because its acceptability rests on the people's cultural, religions and economic considerations. In developing this pilot program in my district , I used a person-to-person approach to motivate the people, and its campaign slogan was "Tell the People". The program itself went like this. A mobile team was set-up that first held meetings to discuss the problems of health education and communication with the village leaders, then it traveled to the villages to campaign. Well-known and respected residents were selected to undergo a one -month training program in health education and family planing at the health center. They were then sent back as home visitors to encourage attendance at the clinic and to follow-up new family planing acceptors. Each home visitor was accompanied by the mobile team. General entertainment films and health education activities were held for the villagers, who seldom had diversions after their working day. Our success was indicated by the increased number of people who came to the center for family planing advice.

Communication in health education activities with the people on their own terms, therefore, proved to be crucial. Monthly meetings were held for the public where panels comprised of a doctor, a teacher, a Buddhist monk, housewives and health education works, (truly an intersectional group) discussed issues and answered questions from the audience. To add importance to the meetings, arrangements were made to have them televised. Because the headman is considered to be one of the key leaders in village life, monthly meeting were also held for them to become familiar with and supportive of the family planing campaign. As a result,

could benefit them, and what were the correct family planing procedures and results. I also asked them sincerely to give me their support (instead of dictating to them what they should do). Even the mayor asked them to help, and a local merchant gave them dried noodle packages to compensate them for their time. The pedicab drivers were so impressed that from that time forward, they not only promoted family planing but they also helped to transport patients to and from the health center, giving them moral support and reassurance in the meantime.

The success of Muang Phon Family Planing Program was such that it was adopted by the MOPH as the model for a nation-wide program. I would like to emphasize that this program required village people and all of their leaders to be directly involved in and largely responsible for the activities we proposed. ***This, above all, meant that the people must understand, accept and be willing to adopt what we regarded as important for their well-being.*** When they were given paper information in a setting which was comfortable to them and achieved a functional understanding, their willingness to help had no boundaries. Great potential and actual resources could be mobilized from the common good.

Clear Understanding

The real key to delivering acceptable health services, though, does not solely rest with creativity. Instead, it centers firmly on clear understanding the social, cultural and economic life of the people for whom the health services are intended. This clear understanding of health status is what should guide the development of services and their provision so that they will be found accessible, acceptable, adequate and effective.

Over the past few years, many research studies have addressed such social, cultural and economic issues is an attempt to understand people's health behaviors. On my past, I have given several such cases, but permit me to give you one other actual case study and for which, I believe, you

whenever a mobile team arrived at these villages, they were met by village headmen who had already arranged a suitable location for the operation and attendance was always very good. Later on, we included such training of health and family planing matters for school headmasters who are also very influential figures in village life.

Natural and Unexpected Leaders

But in village life though, politically recognized leaders are not always the only leaders in affecting people's actions. Other people, who on the surface are simply average community. Let me tell you another story which happened to me.

One day, three men were on their way to Muang Phon Health Center where I worked. They came on a pedicab and, like many curious people, the driver asked them why they were going there; none of the men looked sick. They said they were going to have vasectomies, and asked if the driver thought it was a good idea. The driver, not knowing about the procedure, gave an answer which reflected his own personal belief, namely, that a vasectomy would impair the health and virility of a man. He said "***If I were you, I would not go to the health center for a vasectomy, even though Dr. Krasae is a good doctor. I don't know about you, but I have to work hard for my family. Once a man is vasectomies, he will be weak and cannot do hard work as usual.***" The three men, although having the burden of large families and having mage decision to be sterilized, nesitated after listening to me driver, and two of them finally changed their minds.

When I first heard about this, I was angry. But then I thought, if pedicab drivers are this influential then maybe if I give them the correct information, they will help the family planing campaign. With the assistance of local businessmen I held a meeting with Muang Phon's pedicab drivers, explained to them about the campaign (in their own terms) and how it

will be quick to pick up the core meaning health education activities without being told. It goes like this.

A man came to a health center one day with a large open wound on his leg. He said he had fallen out of a tree while picking fruit and a branch had punched his shin. I treated the man by cleaning the wound, suturing it, and providing him with medicines. I also asked him to come back everyday for wound cleaning and dressing , and I emphasized that this service was going to be free of charge. If the man did not come everyday, his wound might become infected and he could lose his leg or his life.

Five days passes but the man never returned. On the sixth day, this very patient did come back with split/infected wounds. I asked him why he did not come on time. He replied simply that he appreciated the free services, but the cost of transportation from his home to the health center was so high that he could not afford to come everyday.

This case study demonstrates a long-attested fact of life in the poverty-stricken rural areas of the developing world. Namely, people who are poor are more worried about where their next meal is coming from than what "might" occur if they adopt or do not adopt a new health care or prevention behavior. Economics far outweighs health as their primary concern. To rural people in developing nations, and to their urban counterparts as well, health is often an unfelt thing; we do not realize its importance until we are ill. Even when we recover or are not sick, we generally take it for granted. When a person feels well, when his body functions normally, that is all one can ask. The time to seek medical aid is when one does not feel well, when one's body is not functioning normally. Since much of preventative medicine is based on the philosophy of taking action before illness appears, through immunization that prevent it, or through early detection that increases the likelihood of successful treatment, traditional rural people are not the best candidates for this branch medicine. Improving a part of one's life which is not readily felt(such as a hunger pain) and of which are not always aware,

therefore, comes to have little meaning. People's values and world view are directed more at the here-and-now rather than a future orientation. Moreover, this world view is much wider than that of Eastern people's who have been socialized over centuries in the value of preventative behavior. Thailand's world view encompasses not just health but economics and religious belief and values, as seen most in the fatalistic attitudes of rural people.

How then can health education programs be successful? My experience and that of others suggests that health education activities are more likely to be accepted if they are ***"blanketed in"*** with or sold ***"package deal"*** along with curative medicine. The advantages of the latter are tangible and can more readily be demonstrated to patients. In actuality, this ***"blanketing phenomenon"*** is already evident in the immunization programs of many countries. In Thailand, BCG vaccinations are exceedingly effective largely because they are provided at birth, provided the child is born in the hospital and is given an immediate injection. When this is not the case, they are harder to account for.

Such blanket programs should also not focus only on the individual, but the family. In one percent incident, a woman brought her five-year-old daughter to a local hospital, and the youngster was diagnosed as having measles. The doctor asked the woman if her daughter had ever been vaccinated for any diseases and she responded, "No". she did not see the need for it, though the cost was within her capability. The doctor patiently explained the consequences of the disease to her and, nothing that she had also brought along her infant son, indicated that he could become sterile if he contracts a severe case of measles. The woman, desperate with worry for her daughter, immediately saw the necessity of prevention (in the curative context). Furthermore, rather than getting immediate treatment just for the daughter, she promptly had her son vaccinated and began an immunization schedule for both children. In shot, although health education emphasizes

disease prevention and health promotion, oftentimes these need to be presented in a curative context.

Meeting Health Education Challenges.

I offer these small examples of my past experiences as a rural doctor to highlight what I refer to as using social and political opportunities as assets in the provision of health services. It is also an example of the kinds of approaches that have been developing in Thailand in response to the needs of the people. But presently my medical duties in Muang Phon district are not what they used to be, primarily because of my current university position. However, I still return to Muang Phon each weekend as a community member and leader to try and organize people to understand health and environment.

One project, in which I am currently involved, entails the potential roles elderly community members can play as health education leaders. And I would like to present the project's formal background as a final example of a complementary health education strategy.

The Elderly as Potential Education Leaders

In a few Thai provinces, one such complementary primary health care strategy is beginning to evolve as the elderly organize themselves into "Aging Societies". Although these societies are usually founded to promote mental and physical health among staging members, support for the elderly as community heath information communicators stems from a number of sociological, anthropological and public health sources.

On an overall basis, their success has its origin in the Thai value system, its Theravasa Buddhist religions tradition, and the elderly's traditional community health role. Elderly community members oftentimes control resource utilization, in part from their longevity and sometimes the direct ownership of material and financial resources. Yet for Thailand, it rests more heavily on the cultural value that children, at any age, will economically, deferentially and

effectively support their parents and abide by their wishes whenever possible. This expectation is viewed as a child's obligation to his/her parents for having borne, care for, and raised the child. It is a tradition deeply rooted in Thai secular culture, firmly linked to the broad normative structure, and epitomizes the patron-client model of social relations thought by many to be the pervasive made of interaction in Thailand.

Assisting fellow community members is also a means for the elderly to accrue religious merit, which is especially important as each person reevaluates his/her life and searched for ways to enhance their current existence and future rebirths (as based on the Law of Karma). Further, two of the most important precepts of Theravada Buddhist philosophy, i.e., self-reliance and community participation in merit-making, parallel those of primary health care. As public health programs and projects in Thailand (ranging from family planing to environmental sanitation and disease control) demonstrate, greater success is achieved when this religion's canons and adherents (e.g., monks, the elderly) have sanctioned their objectives.

And lastly, Thai elderly have traditionally served as community and family health care provides and advisors. They have a keen ability to integrate health conditions and information (be it traditional or modern) with the existing community structure and village culture. Oftentimes, they serve as the basis for referral to other health provides and are crucial in controlling whether or not prescribed treatments are adhered to.

Primary health care professions realized early on that if this role could be supported and strengthened through health education training, the elderly could effectively extend health care information to all families. However, at present the Thai Ministry of Public Health(1987) recognizes that no effective systems or governmentally sponsored activities are readily available to provide opportunities for the elderly, especially those with high qualifications and vast experience, to make beneficial contributions to their communities. In

actuality, the elderly are even becoming a greater untapped resource as their number has almost doubled within the last 20 years, and the growth rate is faster than the rate of population increase as a whole. Strengthening this health promotion role is one way to partly achieve the official policy objective of maintaining the elderly as active societal contributors in a way which promotes self-esteem and corresponds to cultural values, social roles and their life course stage.

The Aging Society of Muang Phon : A Case Study

one complementary community-based primary health care promotion model is best illustrated by the Aging Society of Muang Phon, Khon Kaen province in Northeast of Thailand, which has developed a true "Health for All" perspective. Moreover, their inner drive, dedication and health message is spreading not only within the region and country, but also to other nations.

The Aging Society of Muang Phon's roots grew out of my own experiences, that is, I was continually confronted by elderly Muang Phon community members who complained of intestinal discomfort and muscular/joint stiffness. No matter what modern medical treatment I attempted, these same symptoms reoccurred. Upon interviewing a number of my patients though, I discovered one common theme, which upon further investigation is also a common pattern in many Thai villages. That is, the elderly generally spent part of the day (esp. frequent Sabbaths and holidays) sitting or kneeling at the local Buddhist temple in meditation. This practice allowed them time to personally interpret their lives through religious beliefs, especially as their concern with the after-life was increasing. They briefly interrupted their meditation periods to eat together, and talk about the events in their life and community. Needless to say, this pattern of extended immobility disrupted the normal digestive process and, coupled with prolonged sitting, brought about their major complaints.

Resorting to a more holistic treatment, I suggested they compliment their religious activities with regular group

exercise, an undertaking that would simultaneously improve spiritual, mental and physical health. On the one hand, public health professionals and health promotion advocates have long recognized that regular aerobic exercise is a key behavioral ingredient in lowering the risk of illness and improving productivity. Further, research evidence shows psychosocial benefits (e.g., social support) also exist and can protect individuals against a variety of health related problems (Ibrahim and Yankauer 1988). On another hand, my "prescription" was conductive to religious values in that any distractions(e.g., pain, flatulence) during meditation would hinder concentration and the attainment of religious objectives.

At first the group was apprehensive, but, after a field trip to Lumpini Park in Bangkok, where elderly people often exercise, and learning by example how exercise firs in with their religious goals and values, they realized physical exercise was possible and personally fulfilling. They then eagerly accepted instruction from a group of Chinese exercise specialists and, out of their joint interest and activities, formally organized themselves into the "Aging Society of Muang Phon" in 1985.

From that point to now, Aging Society members have practiced daily at least two forms of physical exercise, i.e., Singaporean aerobics (a much slower from of Western aerobic dance) and, more importantly, Chinese Tai Chi(Kai). This latter technique, which the elderly enjoy most, use18 selected bodily movements (similar to those in martial arts) conducted in synchrony with a participant's breathing pattern. This exercise clears the person's mind of all extraneous outward worries, while centering his/her concentration on achieving a harmonious, relaxed balance between the mind and body. One psychological benefit is teaching the person to control his/her emotion, muscular control and coordination. As a result of this exercise regime, the perceived health of every member has increased, and the number of major complaints has fallen drastically. Members even report their diabetes mellitus conditions have been easier to control (some even feel they

are "cured"), respiratory illness incidences have decreased, arthritis attacks (especially in the knee, hip, shoulder and back areas) are either fewer or less painful, and their sex lives have improved immensely.

While originally composed of less than 30 individuals, the Aging Society of Muang Phon has grown to include approximately 300 registered members, although 175 are officially active on a daily or weekly basis. The age distribution rages from 45 to 83 years, with an average age of 55. Two-third of the Society are women, one third are men, and members come from differing communities within and outside of Muang Phon District. Further, the occupational structure is represented roughly by 10 percent active businesspersons, 10 percent retired government officials, and 80 percent retired or semi-retried "others" (e.g., teachers, housewives, village headmen, taxi and tricycle drivers); in totally, every economic level is included.

To its members, the Aging Society functions as a social support mechanism which promotes personal and community health and, most importantly, social solidarity. The Aging Society accords its members with three major forms of psychosocial support. That is, emotional support wherein members realize mutual feelings of caring; esteem support in which members, individually and collectively, perceive themselves as having a defined position in a system of communication and obligation. All of these express communicated caring and are seen in the Aging Society's joint activities, as well as in times of personal crisis (death of a family member or a Society member).

Each group member possesses a yellow shirt which depicts lotus flowers in various stages of growth and symbolizes the group's identity. The yellow color cognitively represents religious ideals, and parallels the saffron robes worn by monks. Likewise, lotus flowers have a similar implication; but Society members incorporated into the design a large, fully opened flower containing a candle in its center. They fell this communicates their joint desire to light the way in achieving

health for themselves and for everyone. These shirt were purchased out of the Society's monthly membership fee, which is determined on a sliding scale. Members who can contribute 100 Bath (US$ 3) or more per month, do so eagerly; those who can contribute only 1 Bath or nothing, are equally accepted and are not stigmatized in any way. Everyone is seen to benefit equally from the collection, since the Society is viewed as a community activity, for the benefit of the community, rather than anyone specific person or group of persons. Along a similar line, one Aging Society member is planning to donate land on which to build a community center (not a senior citizens center) that will serve as the focus for Aging Society, community and district health and social activities.

The Aging Society, moreover, has taken their dedication towards health promotion several steps further by actively seeking out and communicating health information, as well as actively integrating and supporting local health personnel. District health officials, for example, at the request of Society members have provided group instruction in nutrition, dental care, child care and mental care. The director of the hospital in a nearby district (Wang Yai) was so impressed that he joined the group himself, although he is only 30 years old. He, as well as the head of Muang Phon's Maternal and Child Health clinic (another 30 year old member), have expressed a dedication to more actively use the elderly for promoting better child care practices in the hopes of controlling high ante-natal morbidity and mortality rates. They see this as an effective strategy since many elderly women are the main child care-takers in their families and view this activity as their major responsibility and joy in life. Mothers also have expressed increased confident in leaving children with the elderly since the latter are perceived to have even greater modern health care knowledge than the mothers, themselves. On Sundays, these elderly persons, who often bring their grandchildren with them, conduct their exercise activities at the Muang Phon Commercial and Technical College (an institution devoted to educating the rural poor) so students can also join

in the program as well. This has the added advantage of giving the group increased public exposure, which raises the elderly's status as health care enthusiasts and communicators even further both in their own eyes as well as the eyes of the community.

More interestingly though, the Society has been actively promoting physical education and disseminating health information on an inter-community "Technical Cooperation Among Developing Villages" style. Primary and secondary school teachers, who travel from as far away as 200 km., frequently visit the Aging Society to learn exercise techniques and health promotion information for use in developing their schools' program. Moreover, the Society has traveled to other districts, provinces and regions to demonstrate their exercise regimes and coordinate of found similar aging societies at the request of villagers, governmental health officials and outside institutions/organizations. The ASEAN Training Center of Primary Health Care Development (ATC/PHC now AIDH), for instance, utilized the Society to organize community members in its Primary Health Care Model Development Project in Nakorn Sawan Province (funded by the World Health Organization). At a local temple, Society members trained the community elderly in physical education, and it improved their ability to work together for a common goal. This facilitated the implementation of community development and communicable/non-communicable disease control programs in the project villages and gave the elderly a higher level of confident in themselves and greater pride in their community.

Several of the elderly are now applying their knowledge in a health care setting. Most notably, the Director of Phon Hospital recognized early on that these elderly were very appropriate health educators, and, if he could support this role even further, the elderly could effectively extend health care information for many families within and between communities. He then approached the Society and asked if any of them would like to work as volunteer health workers at the hospital. Many of the elderly were eager and hospital staff

gave them informal training in hospital procedures, its organization, structure, the functions of each unit and personnel category, as well as the use of health cards, Thailand's health referral system, and PHC education information.

Presently, several Aging Society members work on a daily rotating basis in the hospital. Their primary duties are to act as peer liaisons between patients and their families when they first come to the health facility. They explain about the hospital (as noted above) and help patients to understand why certain procedures are necessary not only for the hospital's functioning, but also for the patient's health. They also lend a sympathetic ear to those who are confused or distressed about their conditions or those of family members.

Their particular value is in dealing and communicating with people in an equal basis. In Thailand's medical system, doctors are accorded a very high status, and many villagers feel uncomfortable in seeing them alone. The elderly bridge this "status gap" as trusted peer communicators in improving doctor-patient relations.

Conclusions

Thailand's primary health education system has expanded over the last 20 years through primary health care program, even rather than the wildest dreams of many involved parties. Its success has led to inter-sectoral (i.e., Ministries of Public Health, Education, Interior and Agriculture) efforts to identify and define the basic minimum needs (BMN) people require in order to apply the primary health care model to community based natural resource preservation. All of

these, though, require involvement of local individuals and authorities beyond the community development model. They require the renewed acknowledgment that rural life, like primary health care, is people-oriented, not program-oriented. And more importantly, growing evidence indicates that health education and communication, at all levels, has an increasingly important role to play in the promotion of health through both personal and collective responsibility.

The Aging Society of Muang Phon exemplifies one integrated health education leadership and human resource development model which can strengthen the decentralization and communication of health information, thus enhancing local and national primary health care program management. The lesson to be learned is that use of a physical education program as a means to solely improve the health of the elderly should not be viewed as an end in itself, especially among its members. For this Aging Society, it evolved by the people into a positive locally acceptable way for people and communities to learn and communicate health education information. The most important component were that developed out of common personal need of key community members but which also had a subsidiary felt and unfelt value to the community at large; it utilized a "learning by example" strategy taught by peers; it instilled feelings of confidence, social solidarity, and achievement; and it incorporated crucial social, cultural, and religious values. Its on-going popular success is based on authentic community participation in an area which now interests and involves many, not just one specific target group. The Society's activities also rest on the ingenuity, insight and flexibility of health service personnel at all local levels as co-workers and supporters in health education and activities which requires their knowledge (which they are often eager to share) but little direct and continued planing and management on their part.

This Aging Society thus demonstrates that even a kernel of knowledge, once absorbed and nurtured can grow by itself. It does not need constant fertilizing by "higher" life (or

organizational) forms. By promoting a sense of togetherness, it can potentially become the center of life and an acknowledge (if not instinctive) approach to life. All it needs is a firm foundation, that is, believing in the wisdom of the people, for only they know the best ways to meaningfully communicate information, be it on health or other development issues.