that smallpox was a punishment inflicted by God, many others that it was due to medicine imported from abroad. Not only were there numbers of people who refused to be vaccinated with imported vaccine, but there were also numbers who deliberately infected themselves with fluid taken from cases, often with disastrous results. He foresaw that it would be a long time before legislation could be enacted to make vaccination compulsory.

The Assembly emphasized the urgency of achieving world-wide eradication, and recommended that the health administrations of the countries where the disease is still present organize and conduct eradication programmes as soon as possible, making provision for the availability of a potent stable vaccine. It also requested the Director-General of WHO to offer the necessary technical guidance and advice; and to provide in his programme and budget for future years for the necessary activities to further smallpox eradication programmes, and for the assistance requested by national health administrations for this purpose.

 HEALTH EDUCATION OF THE PUBLIC

Report of the Technical Discussions at the Twelfth World Health Assembly

"Health education of the public" was selected as the subject for the technical discussions held in conjunction with, though not subject to official action by, the Twelfth World Health Assembly. This choice and the excellent participation in the discussions are evidence of the increasing interest of health leaders throughout the world in health education, which is now being recognized as an essential element in any health programme.

Seminars or technical discussions on the subject have already taken place in each of the WHO regions. Health ministries and other agencies engaged in health education in a number of countries participated widely in preparations for the technical discussions at the Assembly.

To facilitate these preparations, a "Suggested outline for use by countries in discussing health education of the public" was sent by the Director-General of WHO to Member States. It was suggested that this outline be used as a basis for discussions of the subject at the national, provincial and local levels, and that summary reports of the views expressed be sent to the Director-General for the use of participants during the technical discussions.

In addition, the International Union for Health Education of the Public agreed to ask its members to take part in preparatory discussions, using the above-mentioned outline, and to transmit reports to WHO. A total of 61 countries and 3 non-governmental organizations submitted reports of the discussions in their respective countries and organizations. But even these figures give only a small idea of the amount of interest aroused and the extent of the preparatory activity. In one small country, conferences using the outline were conducted in all the provinces; subsequently a national conference was held at which the final report for transmission to WHO was prepared. Another country's summary was compiled from 53 reports submitted by local meetings. The report from one of the non-governmental organizations contained separate statements from 31 organizations.

Using the reports which had been received by 1 January 1959, the Secretariat compiled a "Background document based on summary reports received from countries". This docu-
ment gave detailed examples of practical approaches to health education and recounted some of the wide variations in practice in different countries in respect of programme planning and operation, training of health personnel in health education of the public, and organization and administration of health education services. It also listed a variety of health education problems on which research is needed.

The document was sent by the Director-General to all Member States for their delegates and was available during the group discussions. In fact, the final section, “Suggested topics for discussion”, was used by practically all the groups.

Dr A. Lakshmanaswami Mudaliar, Vice-Chancellor, Madras University, India, served as General Chairman for the technical discussions. He presided over the plenary sessions, and gave general guidance to the Chairmen of the small discussion groups.

A total of 184 people registered for the group discussions, during which eleven working groups spent approximately seven hours each discussing various aspects of health education.

Three well-attended plenary sessions were held: one to introduce the subject, a second at which a lecture on new techniques in health education was given, and a final session at which the reports of the discussion groups were considered.

**FIRST PLENARY SESSION**

Opening the session, the General Chairman referred to the origin of technical discussions as a feature of the World Health Assemblies. He recalled that, following the Third Assembly, the Executive Board had agreed that it would be desirable to give special attention each year to some important aspect of the general health programme. The first technical discussions, held at the Fourth World Health Assembly, dealt with the education and training of medical and public health personnel. At later Assemblies, the following subjects were discussed: the economic value of preventive medicine and the methodology of health protection for local areas; modern health techniques in the control of tuberculosis, syphilis and the typhoid group of fevers; public health problems in rural areas; the education and role of nurses in health programmes; and the role of the hospital in the public health programme.

The discussions were then introduced by a panel which included a nurse, a public health administrator, a public health engineer, a health education specialist and a WHO consultant, i.e., Miss A. Wagner, Director, School of Nursing, Central School of Copen-

hagen County, Denmark; Dr G. Arbona, Secretary of Health, Puerto Rico Department of Health, San Juan, Puerto Rico; Mr H. M. Bosch, School of Public Health, University of Minnesota, Minn., USA; Dr V. S. Erchov, Head of Department, Central Institute for Scientific Research, USSR; and Dr M. Derryberry, Chief, Public Health Education Services, Department of Health, Education and Welfare, United States Public Health Service, Washington, D.C.

The first point stressed by the panel was that the success of many public health programmes depends on health education of the public. It was asserted that health education is “the key to the solution of many health problems involved in the humanitarian task of the World Health Organization” and “the most powerful weapon we have in the field of health”. Instances were cited where sanitation programmes succeeded because of effective health education, or failed for the opposite reason. It was pointed out that, while the value of fluoridating water supplies is well known and the process presents no technical difficulties, lack of effective health education deprives many people of the benefits of this measure. The success of the new WHO programme for providing piped
water supplies will likewise depend to a large extent on the adequacy of the education that accompanies the sanitary engineering phase of the programme.

The need for careful and detailed planning of the educational side of a health programme was also stressed by the panel. Factors to be taken into account include targets, methods, materials to be used, synchronization of educational measures with the rest of the programme, and evaluation procedures. The following points should be considered: (a) extent of the public's knowledge of the subject; (b) misconceptions they may hold; (c) additional information they may need; (d) the best way of making new information available; (e) ways of ensuring that new knowledge is being learned and resulting in positive action.

The panel emphasized the importance of participation by all members of the health team in the planning of health education programmes. In this way, all concerned can fully understand their role in the programme and the contribution they can make. Moreover, people who take part in planning a programme generally have a strong personal interest in its success.

The panel members agreed that all doctors, nurses, midwives, and sanitarians and other paramedical personnel have an educational responsibility. The doctor when he advises a patient or meets a group to discuss a problem they share is conducting health education. The nurse, whether giving advice in the home, taking part in a group meeting at the clinic, serving an industrial group, or providing hospital care, has many opportunities for health education, both organized and informal. The sanitarian also has many opportunities for health education in his work. Although all the health workers mentioned have educational responsibilities, they are nevertheless specialists in medicine, nursing, or sanitary science, not in education. It is thus the task of the specialist in health education to contribute to the health team specialized knowledge about educational methods and techniques.

It was stressed that instruction in health education should be included in the basic curricula of schools of medicine, nursing, sanitary engineering, public health, etc., and should continue during in-service or "on-the-job" training.

In the training of personnel for health education work, practical experience of teaching in the home, health centre, classroom, or community is an essential addition to classroom instruction on methods and techniques of health education.

Various methods of co-ordination were mentioned. These included a centralized system of programme development, some type of co-ordinating council, or an informal planning group. Genuine co-operative effort that assists people to understand and solve their own problems was felt to be more important than the method of co-ordination.

The need for fundamental research by the social scientists on the factors influencing human behaviour and particular health practices was emphasized. Some countries are carrying on limited studies in health education but much more intensive work in this field is badly needed.

* * *

Following the panel discussion, the Chairman requested Mr L. Viborel, Secretary-General of the International Union for Health Education of the Public, to report on the recent Conference on Health Education held at Dusseldorf, Germany, under the sponsorship of the Union. Mr Viborel stated that the theme of the Conference was "Health education of children and adolescents", and attention had been focused on three problems of special importance: co-operation, professional training, and research.

The Dusseldorf Conference stressed the need for more fully developed co-operation between health services, schools, professional bodies and the non-governmental organizations concerned with public health, particularly where the health education of children and adolescents was concerned. It recommended the formation of local health
committees to include members of the various groups and professions participating in health education.

With regard to professional training, the Conference recommended greater attention to health education in medical and paramedical studies, and particularly stressed the importance of health education training for schoolteachers.

The Conference also recognized the increasing interest in intensifying health education research as a means of achieving more effective programmes. It advocated enlisting the collaboration of psychologists and sociologists to assist in developing and conducting research in this field.

In tribute to the work and leadership of the World Health Organization in the field of health education, Mr Viborel said the International Union for Health Education of the Public was proud to participate in the Organization’s health education work.

The General Chairman then reminded those present that participation in the discussion groups would be informal and that those taking part would be doing so as individuals and not in any official capacity.

SECOND PLENARY SESSION

At the Second Plenary Session, Dr W. Emrys Davies, Headmaster, Yew Tree Secondary School, Wythenshawe, Manchester, England, Education Officer to the Central Council for Health Education, England, from 1952 to 1956, demonstrated some new techniques used in health education. He showed several interesting visual aids, including: flannelgraphs that may be used to simplify the presentation; drawings to test word meaning; and a revolving cut-out of a ship to illustrate how one’s past experiences influence what one sees in a given situation. Some of the main points in Dr Davies’ address are given below.

The task of the health worker in his health education effort is to encourage everybody to take that action which will assure the health, happiness or well-being of himself and those close to him. Therefore health education should be judged by what happens to people rather than by the amount of materials used and distributed.

The action that people take is based on a personal decision. That decision depends on a favourable attitude. Hence, in education it is not enough to give people information or knowledge. They must be brought face to face with responsibility for their own health; in other words, they must achieve insight. The learner must share with the teacher in the development of the solution of a problem, that is, there must be participation.

All people are unique personalities with different wants, different capabilities, unique backgrounds of experience, differing understanding of language. Therefore the health educator must know the people with whom he is working. Because words mean different things to different people, it is necessary for him both to check what people understand by what he says and to use simple visual and other means to illustrate the information he provides. Such material needs to be clear, accurate and inexpensive, to be made in the region where it is to be used, and to be tested out with the people for whom it is intended, in order to avoid misunderstanding. In his enthusiasm to convince people of the importance of a health fact the health educator should not use words or visual aids that exaggerate the truth.

In their educational approach health workers should not assume a superior or authoritarian attitude but should behave as partners in the solving of a problem. Suggestions should be made in a way that allows the learner to accept them within his own framework of behaviour. As educators, health workers must maintain their own serenity, and not become involved emotionally.

There are many groups—religious, social, leisure, working, etc.—with similar interests. It is with these natural groups that health educators should conduct group discussions, assisting them to make decisions about their own individual and group health behaviour. Such groups require understanding leaders, who can serve at the same time as partners and advisers to their members.
GROUP DISCUSSIONS

The Chairmen and Rapporteurs of the eleven discussion groups were:

Group 1: Dr B. M. Clark, Deputy Chief Health Officer, Union of South Africa (Chairman); Dr V. Ramakrishna, Assistant Director-General of Health Services (Health Education), India (Rapporteur)

Group 2: Professor G. A. Canaperia, Director of International Relations and Cultural Activities, Ministry of Health, Italy (Chairman); Professor Dorothy La Salle, Professor of Physical and Health Education, Wayne State University, Detroit, Mich., USA (Rapporteur)

Group 3: Dr H. B. Turbott, Deputy Director-General, Department of Health, New Zealand (Chairman); Dr D. A. W. Nugent, Specialist Hygienist, Ghana (Rapporteur)

Group 4: Dr J. N. Rodriguez, Directeur de Disease Control, Philippines (Chairman); Miss Mary J. Kraft, Health Education Adviser, United States International Co-operation Administration (Rapporteur)

Group 5: Dr C. Diaz-Coller, Director de Estudios Experimentales, Secretaria de Salubridad y Asistencia, Mexico (Chairman); Dr S. Haraldson, Medical Officer of Health, Sweden (Rapporteur)

Group 6: Professor E. J. Y. Aujaleu, Directeur général de la Santé publique au Ministère de la Santé publique et de la Population, France (Chairman); Dr E. Duhr, Médecin-Inspecteur de la Santé publique, Luxembourg (Rapporteur)

Group 7: Dr J. Anouti, Director-General, Ministry of Public Health, Lebanon (Chairman); Miss Annette Le Meitour, Chief of Publications, League of Red Cross Societies (Rapporteur)

Group 8: Dr Robert Yoho, Director, Health Education, Records and Statistics, Indiana State Board of Health, USA (Chairman); Mrs Kate Katzki, International Conference of Social Work (Rapporteur)

Group 9: Lt-Col. J. Singh, Director-General of Health Services, India (Chairman); Mrs Sally L. Smith, International Conference of Social Work (Rapporteur)

Group 10: Dr G. F. Amyot, Deputy Minister of Health, Department of Health and Welfare, Victoria, Canada (Chairman); Dr Agnes Singendook, Federal Committee for Health Education of the Public, Germany (Rapporteur)

Group 11: Dr C. M. Norman-Williams, Chief Medical Adviser to the Federal Government, Nigeria (Chairman); Dr J. D. Hourihane, Deputy Chief Medical Adviser, Department of Health, Ireland (Rapporteur)

The reports of these groups are summarized below.

* * *

"In my opinion health education is as important as teaching people to read and write," said a member of one group. "In my country people need to learn what to eat, they need to understand the importance of clean water. Who will teach them?"

"I am responsible for organizing health education throughout my country," said another. "Nothing exists. How will I start? On whom will I call to teach the population? On the doctors? On the nurses? On the teachers? Who will coordinate the programme? And, above all, who will teach those who are to teach the population?"

A health administrator remarked: "I can count neither on my doctors nor my nurses for the health education of the public. They have no time. I need specialized health education teams."

These are typical of the practical and realistic problems raised during the group discussions.

Those groups which sought a definition of health education were generally agreed that it is more than mere information or propaganda. It is a continuing and active process of learning by experience. It is one of the fundamental public health methods that assist in achieving the goals of a public health programme. It is not a programme distinct from other public health programmes.

Planning and operation of programmes

The groups emphasized the importance of planning as an essential element in effective health education. As one group expressed it: "Planning is the oil which enables the programme to work smoothly and effectively."

Elements to consider in planning include: the importance of the health problem; the economic consequences of the problem; the role of health education in the solution of the problem; a clear definition of the population group the programme will affect; the knowledge, attitudes and behaviour of the
people in this group; local conditions, including customs, habits, religions, beliefs, etc.; a clear statement of objectives, including what is to be taught and to whom; the proper timing of health education in relation to the provision of health services; acceptability of the programme to the community; availability of funds and personnel; possibility of getting support from international organizations. From such data it is possible to make an “educational diagnosis” and prescribe the necessary “educational treatment”.

However, it was felt that caution was required on two points. First, over-zealousness in the conduct of health education may result in demands that will overtax the resources of the community, thus causing adverse reactions to the health programme, and destroying the people’s confidence in the health authorities; secondly, the health education adviser should take into account the implications for other social programmes operating in the community that may require financial support for their success.

It was generally agreed that all personnel who are to take part in the programme should also take part in the planning. This enables them to determine the contribution they can make. Furthermore, community leaders as well as the beneficiaries of the programme should be asked in advance for their advice. Teachers and other persons in contact with the people form an important health education resource which should not be overlooked.

Several groups called attention to the need for flexibility in planning so that procedures can be varied to take into account differences among communities or unexpected situations that may arise.

Three groups considered the degree to which communities can be led to take health action. The use of legislation was suggested but it was noted that when health laws are enacted there is need for health education to make them more acceptable to the people. One group discussed the use of competition between individuals and social groups. The success of this method in particular areas of the world was cited, but the group observed that there was a potential danger in competition as a motivating force, since it may produce unhappy feelings in some people and the emotional reactions may lead to failure. The group agreed that competition is usually unsound. It might be useful to some extent between institutions or communities, but not between individuals.

The groups were agreed that the methods employed in health education for any group will depend on local factors. No one method can be applied effectively in every circumstance. Practical methods for each situation should be developed by the community with the guidance of health education specialists, if available.

Some of the groups’ comments on specific methods are given below:

(a) Surveys. If these are carried out by the people, they often stimulate both interest and action, but unless local investigation can be followed up by appropriate services the confidence of the people may be lost.

(b) Enlisting key individuals to demonstrate better health practices. This method is often useful but a thorough understanding of the community is necessary in order to avoid choosing the wrong individual or family as a model, and to prevent jealousies and misunderstandings of the motives for the choice.

(c) Group discussions. Several reports mentioned the effective results obtained when local groups discussed their problems and made their own decisions about improvements. This method is only useful when the groups meet together naturally, and have common interests and similar problems.

(d) Lectures and formal teaching were not considered as ideal methods, but where they are used they should be simple, clear, and not too detailed. They are usually most effective if given to groups with a special interest rather than to general groups. Good questions put at meetings can introduce new ideas but it is more effective if they are introduced casually.

(e) Campaigns. The effectiveness of campaigns in producing any real change in
health habits was questioned. A succession of campaigns should be avoided as the population is apt to become surfeited.

(f) Person-to-person education. Discussions between the health educator and individual members of the public were recommended as the most effective means of education, as for example in the interviews conducted by doctors, nurses, sanitarians and health education specialists.

A few groups considered types of health education material and their place in the programme, reaching the following conclusions: to be effective, health education materials should not consist of dead museum exhibits, but should show things in a lively way, local colour being added to arouse interest; materials obtained locally for specific objectives and needs usually produce better results than more costly materials produced at a central office; exhibitions are of little interest to urban populations but still retain their value in small centres and rural areas; the flannelgraph appears to be an excellent medium for health education; in under-developed countries radio and films are likely to have a much greater impact than the press; as sufficient time is rarely allowed for testing materials before they are used, such testing should be done among the groups or population for whom the programme is intended.

Several groups felt that the value of materials was not to be measured by their cost. Inexpensive materials properly used should be the aim. By adequate budgeting and judicious selection, a proper balance can be achieved between expenditure on materials and expenditure on the essential task of training people to use them.

There was general agreement that in the planning of health education, provision should be made for evaluation of efforts from the very beginning. Health education activities should be subject to the same degree of critical evaluation as all other activities in the programme.

It was pointed out that a real evaluation of health education is extremely difficult. To evaluate in statistical terms, the objective has to be clearly defined, and units of measurement need to be developed so that results can be checked against the aims of the health programme. What is particularly difficult in the evaluation of health education is to determine its contribution to a successful result in relation to other factors. Perhaps the best indication is the extent to which the people participate.

It was suggested that WHO might assist in the evaluation of health education, and act as a clearing-house to provide administrators with the experiences of others in such evaluation.

Training of health personnel in health education

Discussions on training centred around three major topics: health education training in the basic preparation of health personnel; continuing or in-service training in health education; and the responsibilities and training of the health education specialist.

There was complete agreement among the groups that all health workers—physicians, nurses, midwives, health visitors, social workers, engineers, sanitarians and their auxiliaries—have responsibility for the health education aspects of the services they render and of the programmes in which they participate.

In addition, it was recognized that teachers, recreation and youth workers, agricultural extension workers, fundamental education specialists, publicity and public information workers, community development workers, community leaders and others have an important contribution to make to the health education of the public.

Several of the discussion groups worked out in detail the training each category of personnel required to discharge this responsibility effectively. It was considered desirable that their training should equip them with: knowledge of how people learn (the problem of motivation and resistance in health matters); an understanding of the importance of traditions, habits, values, superstitions and the general way of life of any community, its power structure and leadership; a know-
ledge of methods of ascertaining such information; skill in the use of education methods and media; skill in human relations and teamwork.

There was general agreement that training in health education should be a regular part of the curricula of the various institutions responsible for the preparation of professional health workers. In several groups, it was pointed out that in some eastern European countries all public health physicians are required to take post-graduate training in health education. In their work as members of salaried medical services, they must then devote a certain number of hours to health education each month. In other countries, however, where doctors do not receive a salary, but earn their living by private practice, the trend is definitely towards a greater interest in clinical medicine, and medical training is geared towards this end. In these countries changes need to be introduced in the curricula of medical schools in order to arouse the interest of the students in preventive and social problems. Some encouraging local experiments were mentioned where students are assigned to a family or group of families in the community as medical observers rather than advisers. It was considered that such programmes should be encouraged so as to produce in the future medical practitioners concerned with public health and social problems who can co-operate in health education activities to a greater extent.

Unanimous agreement that training in health education should be given to all health personnel as part of basic professional preparation was accompanied by an equally unanimous recognition that this would not be easy to accomplish. Some of the obstacles mentioned were: the difficulty of trying to change long-standing educational traditions; the difficulty of trying to change the attitudes of teaching staff, particularly senior members of the faculty; the shortage of highly qualified health education specialists to do the teaching; shortage of funds; the possible prolongation of study time in an already overcrowded curriculum; the revision of curricula, a task which demands research and thorough analysis of existing programmes and future aims.

Continuing in-service training was considered by all groups to be vital to the development of effective health education. Such training is needed not only for newly prepared workers, but is especially required for older personnel who may have had no health education training in their basic professional preparation. The groups made various concrete suggestions: inclusion of provisions for in-service training in the budget and programme of health administrations; recruitment of an adequate qualified teaching staff; integration of health education into every further-training programme; publicizing successful seminars or similar meetings in order to increase the demand for in-service training in health education by health workers; keeping in touch with field workers through monthly newsletters or bulletins; provision of fellowships; careful selection of staff members to attend seminars so that they can share experiences and information with their fellow workers when they return; conduct of seminars and study groups in a manner that provides for the active participation of all members, rather than reliance on formal or didactic meetings.

It was pointed out that it is often better to provide training in the rural health centres than to bring staff to the urban areas where they are tempted to remain. Wherever possible, in-service training should be carried on in such a way that the health workers can all be lodged in common quarters. Such an opportunity for the informal sharing of experiences and frank discussions helps the health worker to improve in his profession and develop as a human being.

In one group a participant described a unique combination of academic and in-service training. A seminar was arranged in which students of an advanced health education course were able to discuss the content and methods of health education of the public with practising health workers of different disciplines in a different country from the one in which the course was held. This procedure stimulated the health workers to learn more about health education and gave the students experience in adapting
what they had been taught to conditions in a new country.

Health education seminars were suggested as a useful means of persuading administrators of the value of in-service training in this field. It was also suggested that WHO experts might be asked to start national health education training programmes, and to sponsor meetings of health education specialists and health administrators to bring them up to date on new techniques, methods, principles, etc.

It was generally agreed that there was need in every country for at least a limited number of health education specialists. One group felt that such personnel are needed at all levels of health organization though it was recognized that it would not always be practical or possible to use highly skilled staff at the local level. In general, it was considered that the health education specialist should be a highly qualified person, capable of working on equal terms with programme directors and administrators as an adviser or consultant.

The duties of the health education specialist were considered to be: assisting health staff and others to plan and carry out the health education side of their programmes; organizing and participating in health education training programmes; assisting with the selection, preparation, pre-testing, distribution and utilization of appropriate teaching aids and health education materials; co-ordinating all health education activities in the health organization; enlisting the advice of anthropologists, sociologists, psychologists and psychiatrists whenever their special skills will contribute to more effective health education.

There was not complete agreement concerning the qualifications needed to perform adequately the duties of a health education specialist. Some participants thought that he should be a doctor in order to have higher status and greater influence with the authorities. Others concluded that he need not necessarily be medically qualified, and one group considered that if the health education specialist is to teach, medical training is wasted on him.

Despite this lack of agreement on the basic professional training required, all were agreed that the health educator needs a university education, or its equivalent, with a sound knowledge of the behavioural sciences and educational methods, including audio-visual techniques. He should have strong leadership ability, be genuinely interested in people and their problems, be warm and out-going, and want to make health education his vocation.

It was pointed out that most countries could anticipate having in the near future only a relatively few qualified health education specialists; consequently they should be carefully selected and their training well planned as a part of a long-range programme.

It was recommended that only experienced and mature health workers with some years of practical health education work in their own countries should be sent abroad for specialized training.

WHO was commended for its sponsorship of training in health education, and it was hoped that the number of trainees might be increased each year.

Organization and administration of services

There was complete agreement on the desirability of a health education unit at the national level to co-ordinate the work of health education throughout a country. A majority of the groups felt that this unit should be a part of the central health administration, though others were of the opinion that the task of co-ordination could be entrusted to private agencies working in co-operation with the official health administration. It was suggested that, in some countries, technical units of health education might be desirable in the official education agencies as well as in voluntary health agencies. While agreeing that there should be some type of health education unit in every country, the groups all pointed out that the great differences in culture, educational levels of the people, and financial resources made it necessary for each unit to study its own situation and develop the type
of administrative structure best suited to its own needs and problems.

The general services expected from the health education unit are: participation with other technical units in planning for and carrying out the health education aspects of health programmes; assistance with the organization and conduct of in-service training in health education for health workers, in the Ministry of Health and in related agencies; studies of the health education needs of the country or area served; promotion of co-ordination between similar services in other government departments (education, social affairs, and social insurance) and in voluntary and professional health organizations; direct co-operation on the school health programme with the department of education; planning and developing appropriate teaching aids and health education materials; conducting health education demonstrations for the improvement of methods and material.

Although the exact position of the health education unit in the organizational structure of the country would vary, it was the general consensus of opinion that the unit should be placed at an administrative level which would grant it enough executive authority to carry out its own activities and to establish working relationships with both the public health and curative medical services. It should have sufficient independence to be able to offer technical advice without the necessity of going through a multiplicity of administrative channels.

Most members felt that the central unit should act in an advisory capacity where there are health services at the provincial and local levels. A few expressed the view that local units should not enjoy too much autonomy, but should be executive organs carrying out field activities in accordance with an agreed policy.

The participants felt that, depending on the needs and resources of the country, the central unit should be staffed with health education specialists, doctors, teachers, information specialists and personnel specializing in the production of materials. Sociologists, cultural anthropologists and psychologists could also serve on the health education staff.

Most groups believed that the administrator should be a physician specializing in public health and having a comprehensive training in health education. It was pointed out that in some countries professional health education specialists—not necessarily doctors—have helped to raise health education activities to a highly satisfactory level.

Several groups discussed health education auxiliaries as members of the health education staff. But the term did not have the same meaning to all the groups. To some "auxiliary workers" referred to fully trained paramedical personnel, such as nurses and health inspectors; to others the term meant volunteers who participate in community health education efforts; and to still others it meant sub-professional workers with a limited amount of training in health education.

There was no agreement about the role of the sub-professional worker. One group felt that the use of such poorly prepared personnel was definitely inadvisable. The funds devoted to their employment could better be spent on paramedical personnel who could render services to the population and at the same time carry on health education. Others mentioned that in underdeveloped countries such workers could make contact with a large mass of the population who cannot be reached by the more specialized staff. All those who felt that informally trained personnel should be utilized stressed the need for the closest possible supervision and guidance of their activities by professionally qualified health education specialists. One group considered that, although all health workers should be encouraged to engage in health education in the course of their regular work, they ought also to be warned against dealing with matters outside their competence. The warning applies especially to those of sub-professional grades. This temptation is especially strong where, for example, the only representative of the health department to visit a village over long periods is the sanitarian or health education auxiliary, who may be regarded as a "doctor"
and asked for advice on many medical matters.

The question of maintaining staff morale was considered by only a few of the groups. Some of their suggestions in this connexion were as follows: regular staff meetings or conferences, both general and at each level of the service, should be held for the exchange of views and the solution of problems; the administrative staff should take an interest in the work of the health education specialist, have a thorough knowledge of what is being done in health education, and be willing to give constructive assistance with any problems that may arise; steps should be taken to see that the significance of health education is appreciated by the entire health department staff, and that the administrative structure is one in which the health education specialists and the rest of the staff can work harmoniously together.

The participants were all agreed that health education, like all other branches of public health work, seldom has enough funds for sufficiently intensive activities. In general it was felt that the central budget should provide for specialist health education services as well as for routine activities in this field. In the budgets of other divisions—e.g., those dealing with communicable diseases—provision should be made for the required additional educational services and materials. Where possible the central budget might be supplemented by provincial and local funds, or from private sources.

It was emphasized that if there is a separate appropriation for health education services, there must be close co-operation with the special technical divisions of the programme as regards the preparation of suitable educational material and the organization of other educational activities.

All groups mentioned the important role that voluntary health agencies play in health education of the public. One group stated: "Voluntary agencies are made up of individuals who, for one reason or another, have a greater interest and concern with a specific health problem than does the average person. Because of this specific interest, their action is frequently guided by their emotions. This often results in undue emphasis on one problem and duplications or omissions in other areas of public health. However, the important concept is that these voluntary agencies are resources that can be utilized to give strength to the health movement in a given country."

Tribute was also paid to the contribution of universities, of professional groups such as medical, nursing and pharmacists' associations, and of teachers, religious leaders, and others.

However, some groups stressed that before these agencies can make their full contribution to health education there must be co-ordination both in planning and in action. Otherwise conflict or duplication of effort will limit the effectiveness of their activities.

A variety of methods to achieve such co-ordination were described. In some countries, there is an association of voluntary agencies which works with the official health agency. In others, co-ordination is ensured by a national committee consisting of both official and non-official agencies. Where there is a centralized, highly organized administration for health education work, co-ordination is naturally one of its functions. Elsewhere effective co-ordination is achieved through the granting of subsidies by the central authority to assist the health education work of local and non-governmental agencies. When this is done the subsidizing authority must obviously satisfy itself that there is a reasonable measure of co-ordination before the grant is paid.

Regardless of the method of co-ordination the best results are achieved where good human relations exist and the agencies are more concerned with results than with prestige.

Several groups considered the unique role of the press, which sometimes expresses views that may be in conflict with the health authority. Two positive suggestions were made in this connexion. Health administrators might hold periodic conferences with the public and the press concerning developments in the health programme, and the press might be represented on national co-ordinating committees.
Studies and research

There was general agreement that research in the field of health education is of the utmost importance for the success of health programmes. It was pointed out that many programmes fail or are slow in developing because of factors that are still unknown, e.g., why people behave as they do, how man thinks of his own environment, the values in which he believes, and his aims and ultimate goals.

Some groups also mentioned the need for more adequate estimates of public knowledge on various health subjects as a prerequisite to health education. An example was cited of a study in a highly-developed country where it was found that 70% of a sample of schoolchildren aged between 14 and 15 did not know that pulmonary tuberculosis was a communicable disease. It had previously been assumed that this was a well-known fact.

The groups also discussed evaluation studies at some length. These include not only appraisal of the effectiveness of programmes, but also investigation of the reasons for any lack of success, or for failure of people to participate. One group pointed out that to make evaluation possible initial plans should include the collection of base-line data and a clear statement of the problem and goals. One of the members cited an example of continuous programme evaluation as practised in his country. A research team, consisting of a public health doctor, a social scientist and a health education specialist, moves into an area before the programme begins. They gather all the relevant information on the people, their customs, beliefs, knowledge and practices as standards of reference for the measurement of progress. They live in the area, measuring changes as the programme develops. This combination of research and programme development has proved extremely valuable.

The example was cited of a study to determine why people did not avail themselves of a chest X-ray for detecting tuberculosis, although no charge was made. Studies to determine the effectiveness of specific methods and materials were also mentioned. Such studies would perfect the tools of health education and lead to better results for the same amount of effort.

It was generally felt that the services of cultural anthropologists, psychologists and perhaps sociologists are needed to assist in much of the research work described. It was recognized, however, that research in the social sciences is expensive and cannot be undertaken in depth without adequate funds. One group suggested approaching university departments of anthropology, psychology or sociology for assistance in research of this type.

One group pointed out that while it is necessary to engage in research of such complexity that it requires social scientists to direct it, there are studies of a less advanced character that can be undertaken by the health workers themselves, once they are convinced of their importance. This group suggested that much information useful in programme planning can be gained by intelligent listening to the people rather than by always asking questions.

A warning about undertaking too extensive a study without expert research guidance came from one group, which cited the example of a large-scale survey on tuberculosis which was undertaken without the help of any social scientists. The result was most disappointing since most of the answers could not be used because the research has not been adequately planned.

The groups were sufficiently concerned about intensifying research in health education to suggest that WHO: encourage universities to do more research in the field of health education; prepare a document for the use of Member States, setting forth general guiding principles in research and containing suggestions on the types of studies needed; inform Member States of the results of research already done; initiate studies in school health and in the evaluation of public health education programmes; encourage Member States to establish committees on research, by making available research consultants (social anthropologists, psychologists and sociologists), providing special grants,
and by organizing special seminars on the subject; and utilize the International Medical Research and Health Year, if approved by the World Health Assembly, as an opportunity to carry out research programmes in health education.

FINAL PLENARY SESSION

The General Chairman opened the final plenary session by expressing his satisfaction with the useful contributions made by the participants in the group meetings. He invited comments on the draft summary of the eleven group reports.

In the general discussion, many of the points in the draft were singled out for special mention. These included: the importance of detailed, specific, yet flexible planning of the educational aspects of any health programme; the important role in health education of doctors, nurses, midwives, social workers, sanitarians, teachers and all others in frequent contact with the public; the need for basic preparation as well as in-service training in health education for all such workers if they are to discharge their role successfully; the progress being made in health education training of medical and paramedical personnel despite the difficulties involved; the need for a great increase in research efforts in health education; the task of WHO in providing leadership in health education research; the value of consulting social scientists and using their research findings in health education programmes.

The role of the health education specialist was reviewed, as well as his basic qualifications and training. Although some differences of opinion continued to exist among those who discussed this question, the basic functions as listed in the report of the WHO Expert Committee on Training of Health Personnel in Health Education of the Public 3 seemed satisfactory.

Tribute was paid to the technical discussions as an excellent means of sharing experiences and experiments in different countries. It was also pointed out that the freedom for exchange of views within the discussion groups had resulted in much mutual education and, in fact, demonstrated one method of health education.

In a brief statement one of the participants observed that health education was not a programme in the sense that control of a communicable disease was a programme; it was rather a method of public health whereby the knowledge and skill of the physician, engineer, nurse and other health workers could become more readily acceptable to people who could benefit from the services rendered by these workers. The real task of health education was to create an environment in which people could study their problems objectively and find solutions satisfying to them. Over the years through research and experience a body of health education knowledge and skills had been developed which those who engaged in health education should acquire through training. Without such knowledge and skills health workers risked obtaining results quite different from those they intended, for the tool of health education was as dangerous when used by individuals untrained in handling it as was the scalpel when used by an incompetent, poorly trained surgeon.

After expressing appreciation to all those who had contributed to the success of the technical discussions, the General Chairman closed the session by expressing the hope that this meeting was not the end but the starting point for intensified work in all Member States. There was, he said, no end to health education, which would continually grow and change as new discoveries were made.