"Health Education of the Public" was selected as the subject for the Technical Discussions at the Twelfth World Health Assembly. The choice of this topic is evidence of the increasing interest of public health leaders of the world in health education. The excellent participation in technical discussions by persons attending this Assembly emphasizes the growing interest and recognition of health education of the public as an essential element in the success of all health programmes.

Already seminars or technical discussions have taken place in each region of the World Health Organization. In preparation for the discussions at this Assembly there has been widespread participation in the various countries by health ministries and other agencies engaged in health education.

To facilitate the participation of countries prior to the Assembly, a "Suggested Outline for use by Countries in Discussing Health Education of the Public" (Al2/Technical Discussions/1, 31 March 1958) was prepared and sent by the Director-General to Member countries. It was suggested that the outline be used as a basis for discussions of the subject at the national, provincial and local levels. It was further requested that summary reports of such discussions 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 request its members to participate in preparatory discussions using the above mentioned Outline, and to transmit reports to the World Health Organization. A total of 61 countries and three non-governmental organizations submitted summaries of the discussions in their respective countries and organizations. But even these statistics do not reveal the total amount of interest and activity that took
place. In one small country, conferences using the outline were conducted in all the provinces. Subsequently a national conference was held in which the final report for transmission to the World Health Organization was developed. Another country reported that its 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.

Many of the countries and organizations that participated by sending reports to the World Health Organization have indicated their desire to receive at the earliest possible date the final report of the discussions that are being concluded at this session. Thus, the report developed during this Twelfth World Health Assembly will have wide use as soon as it becomes available.

Using the reports which had been received by 1 January 1959, the Secretariat compiled a "Background Document based on Summary Reports received from Countries" (Al2/Technical Discussions/2, 12 March 1959). This document gave detailed examples of practical approaches to health education and recounted some of the extreme variations in practice in the several countries with reference to "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 problems in health education on which research is needed.

The "Background Document" was sent by the Director-General to all Member countries for their delegates and has been available during the discussion sessions. In fact, the final section "Suggested Topics for Discussion" was used by practically all the small groups in their consideration of the subject.

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 group discussions.

The plenary sessions were very well attended and 184 people registered for the group discussions. The participants were divided into 11 work groups who spent approximately seven hours discussing the various aspects of health education of the public.
Three plenary sessions were held: one to introduce the subject and to give
general orientation concerning the procedure to be followed; another at which a
lecture and demonstration on "Some New Techniques in Health Education" was given;
and a final plenary at which the reports of the discussion groups were considered.

The remainder of this document reports a summary of the various sessions.

FIRST PLENARY SESSION

In opening the plenary session, the chairman reviewed the origin of technical
discussions as a feature of the World Health Assemblies. He recalled that, following
the Third Assembly, the Executive Board members 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,
considered the education and training of medical and public health personnel. At
later meetings of the Assembly topics considered were: the economic value of
preventive medicine and the methodology of health protection for local areas; the
modern health techniques applied to the control of tuberculosis, syphilis and the
typhoid group of fevers; public health problems in rural areas; nursing, the education
and role of nurses in health programmes; and the role of the hospital in the public
health programme.

The chairman announced that the subject for technical discussion at the Twelfth
Assembly, "Health Education of the Public", would be presented and briefly discussed
by a panel of health specialists prior to group discussions.

The following individuals, each of whom represented a particular public health
discipline, served on the panel:

Nurse — Miss A. Wagner, Director for the School of Nursing, Central School of Copenhagen County, Denmark.

Public Health Administrator — Dr G. Arbona, Secretary of Health, Puerto Rico Department of Health, San Juan, Puerto Rico.
Public Health Engineer - Mr H. M. Bosch, School of Public Health, University of Minnesota, Minneapolis, USA.
Health Education Specialist - Dr V. S. Erchov, Head of Department, Central Institute for Scientific Research, USSR.
Dr M. Derryberry, Consultant to WHO for technical discussions

Some of the points developed by the panelists in the course of their discussion were:

1. **The success of many public health programmes depends on health education of the public.**

   Assertions made that "Health education is the key to the solution of many health problems involved in the humanitarian task of the World Health Organization" and "Health education is the most powerful weapon we have in the field of health" indicate the strength of the panelists' conviction. Instances were cited where sanitation programmes had succeeded because there had been effective education, and others where the programmes had failed because the education had been ineffective.

   It was pointed out that there are no technical difficulties or lack of scientific knowledge about value and way of fluoridating water...plies but many communities do not enjoy the benefits through lack of effective health education.

   The success of the World Health Organization's new programme of providing a piped water supply to many communities will depend in large measure on the adequacy of the education that accompanies the sanitary engineering phase of the programme.

2. **Effective health education requires careful and detailed planning**

   The educational aspects of any health programme must be planned with as much care as the service or operational phase. Elements in planning include goals to be reached, methods, materials to be used, co-ordinated timing of the service and educational activities, and evaluation procedures. Some of the questions to be considered in the planning are:

   (a) What do people now know about the subject?
   (b) What misinformation do they have?
(c) What additional information should be made available to them?

(d) What is the best way to make new information available?

(e) How will we assure ourselves that the new information is being learned and is resulting in positive action?

3. **All members of the health team should participate in the health education planning**

   The importance of drawing in for the planning all persons who are to carry on a programme was emphasized. It was agreed that by this means all concerned might understand fully their role and how their activities could contribute to the programme. Furthermore, people who have had a part in the planning generally feel strongly that it is their programme and strive eagerly for its success.

4. **Every health worker who comes in contact with people is doing health education**

   The panelists agreed that all doctors, nurses, midwives, and sanitarians and other paramedical personnel have responsibility for health education. The doctor when he advises his patient or meets with a group to discuss with them some problem common to all of them, is conducting health education. The nurse, whether making an advisory visit in the home, meeting with a group at the clinic, serving an industrial group, or providing care in the hospital, has many opportunities for both organized and informal health education. The sanitarian also is a resource for improving health attitudes and behaviour as he works with his clientele. Although all these workers have educational responsibilities, they are, nevertheless, specialists in medicine, nursing, and sanitary science, not in education. The specialist in health education contributes to the health team specialized knowledge about methods and techniques in education. He makes this knowledge available through consultation, participation in planning, and through pre-service and in-service training.

5. **Thorough training of health personnel in health education is necessary to discharge adequately educational responsibilities**

   The point was stressed that health education training should begin in the basic professional school - schools of medicine, nursing, sanitary engineering, public health, etc. - and be continued through in-service, or on-the-job training experiences.
The person who is to teach about health must have a sound knowledge of the subject matter, should know the population groups with whom he works, and understand their interests, beliefs and cultural background. He should also have understanding and skill in educational methods.

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

6. **With many people engaged in health education co-ordination is essential**

Various methods of co-ordination were mentioned. These included a centralized system of programme development, a type of co-ordinating council, or an informal planning group. The reality of 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.

7. **Studies and Research in health education is needed to provide a more scientific basis for health education**

The need for fundamental research by the social scientists on the factors influencing human behaviour and particular health practices, was emphasized. It was also pointed out that there is real need for more practical studies concerning such problems as: the extent and accuracy of the public's knowledge of health subjects and how the health worker can obtain such information about the population group with which he is working; the effectiveness of the methods and materials used; the methods of conducting health education programmes requiring special response from the public; and evaluation of the effectiveness of programmes.

Some countries are carrying on limited studies in health education but much more intensive work in this field is badly needed.

* * *
Immediately following the panel discussion, the Chairman requested M. 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 International Union. M. 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 pointed out 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 the syllabi of medical and paramedical studies, and particularly stressed the importance of training of school teachers.

On the subject of research, the Conference recognized the increasing interest in intensifying health education research as a means of more effective programme implementation. It advocated enlisting the collaboration of psychologists and sociologists to assist in developing and conducting research in this area.

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

The Chairman then reminded the audience that participation in the small groups would be informal and those taking part would be doing so as individuals and not as official delegates from a country.

The names of the Chairmen and Rapporteurs for the eleven discussion groups were announced as follows:
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 techniques based on a philosophy of education. Interesting visual aids included:

(a) flannelgraphs that may be used to simplify the presentation
(b) drawings to test word meaning, and
(c) 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 major points made in Dr Davies' address follow:

The task of the health worker in his health education effort is to encourage everybody to take that action that will assure the health, happiness or well-being of himself and those close to him. Therefore we judge health education by what happens to people rather than 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.

Human beings act on their wants as they perceive them rather than on the health needs as seen by health workers. Some of the human wants are: clothing, food and drink, shelter, employment, success, sexual and social companionship, parenthood and freedom to express one's personality. It is these wants that develop an interest in health, for good health makes its own contribution to satisfying these wants in socially acceptable ways.

All people are unique personalities with different wants, different capabilities, unique background of experiences, differing understanding of language. Therefore we must know the people with whom we are working.

Because words mean different things to different people, we need both to check what people understand by what we say and to use simple, visual and other means to illustrate the information as we provide it. 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 our enthusiasm to convince people of the importance of a health fact we should not use words or visual aids that exaggerate the truth.

In our educational approach we should not assume a superior or authoritarian attitude but 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 we must maintain our 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, and assist the groups to make decisions about their own individual and group health behaviour. The conduct of such groups calls for an understanding leader, who can serve as partner and resource to the group.
GROUP DISCUSSIONS

Each of the eleven groups prepared a full report of their discussions based on the "Background Document". These reports are summarized under the following headings:

Introduction
Health Education Defined
Programme Planning and Operation
Training of Health Personnel in Health Education of the Public
Organization and Administration of Health Education Service
Studies and Research in Health Education
Evaluation of the Technical Discussions

Introduction

"In my opinion health education is as important as teaching people to read and write" was the opening comment in one group. The speaker continued: "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 co-ordinate the programme? And, mostly, who will teach those in charge of teaching 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." Such were some of the practical and realistic types of problems which opened the discussions.
Health Education Defined

In those groups that considered a definition, it was generally agreed that health education 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.

PROGRAMME PLANNING AND OPERATION

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

Some of the 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 the target population
- The local conditions, including customs, habits, religions, beliefs and so forth
- 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, two notes of caution were expressed:

Over-aggressiveness in the conduct of health education may result in demand that will overtax the resources of the community and thus cause adverse reactions to the health programme, and destroy the people's confidence in the health authorities;
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 function in the programme should participate in the planning. Thus it is possible for them to determine the contribution they can make. Furthermore, community leaders as well as the consumer of the programme should be asked in advance for their advice. An important health education resource not to be overlooked is the teachers and all others in contact with the people.

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 motivated to take health action. The use of legislation was suggested but it was noted that when laws are enacted there is need for health education to make the laws more acceptable to the people. The use of competition between individuals and groups was discussed in one group. The success of such a device in particular areas of the world was cited, but the group observed that there was a potential danger in competition as a motivating force. Oftentimes unhappy feelings may develop in some people and the emotional reactions may end in failure. The group agreed that competition is usually unsound. It might be more useful between institutions such as municipalities 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 all the prevailing circumstances. Practical methods in any situation should be developed by the community with the guidance of health education specialists if they are available.

There were, however, in the reports certain comments about specific methods that seem appropriate to include. These are:

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;
Enlisting key individuals to demonstrate better health practices. This method is often useful but a thorough understanding of the community must be gained to prevent the selection of the wrong model individual or family or to prevent jealousies and misunderstandings of the motivation for the selection of the model;

Group discussions. Several reports mentioned local experiences where effective results were achieved when groups discussed their problems and made their own decisions about improvements. This method is only useful when the groups meet together naturally, have common interests and similar problems;

Lecture and formal methods were thought not to be the best. 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 it is done casually;

Campaigns. The effectiveness of campaigns in producing any real change in health habits was questioned. Campaigns one after another are to be avoided as the population is apt to become surfeited;

Person-to-person education. The two-way communication between the health educator and the consumer was recommended as the most effective means of education, for example the doctor, nurse, sanitarian and health education specialist in their interviews.

A few groups considered the kinds of health education materials that can be used and their place in the programme. Some of the points made about the use of materials were:

- health education materials to be of any effect should constitute active demonstrations rather than dead museums and should carry local colour to stimulate the interest of the consumer;
- materials obtained locally for specific objectives and needs usually produce better results than those 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 appeared to be an excellent medium for health education;
in underdeveloped countries radio and films are likely to have a much greater
impact than the press;

usually sufficient time is not allowed for testing materials before they are
used. This testing should be done among the groups or population for whom the
education is intended.

Several groups felt that the value of materials was not to be measured by their
cost. Inexpensive material properly used was the desired aim. By adequate budget-
ing and judicious selection, a proper balance can be achieved between funds for
materials and the essential element of training people to use them.

There was general agreement that in the planning of health education,
provision should be made for evaluation of the efforts from the very beginning.
Furthermore, there should be critical evaluation of the health education activities
just as there is of all other activities in the total programme.

Evaluation

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, the units of measurement need to be developed so that results can be
checked against the aims of the health programme. What is more difficult in
evaluation health education is to determine its contribution to the success in
relation to other factors. Perhaps the best index is how well the people
participate.

Two suggestions about the role the World Health Organization might play in
evaluation were:

assist in the evaluation of health education;

act as a clearing house to provide administrators with the experiences of
others in evaluation of health education.

TRAINING OF HEALTH PERSONNEL IN HEALTH EDUCATION

The discussion of 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 recognised 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 effectively this responsibility. It was considered desirable that their training should equip them with:

Knowledge of how people learn or the learning process; 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 knowledge of methods of ascertaining such information;

Skill in the use of educational methods and media;

Skill in human relations and teamwork.

In addition to such fundamental educational knowledge, all workers would be expected to have a thorough grasp of the health subject matter to be taught.

There was general agreement that training in health education should be a regular part of the curriculum of the various institutions responsible for the preparation of the professional health workers. As one group expressed it, health education is like the health teaching of a mother - post-natal instruction is too late, pre-natal education is essential.
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. After such training, they are employed in a salaried medical service and must devote a certain number of hours per month to health education. In other countries, however, where doctors are not on salary and 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 the latter countries changes need to be introduced in the curriculum of medical schools in order to change the mental attitude of the medical practitioner and orient his interest to preventive and social problems. Some encouraging local experiments were mentioned where medical students are assigned to a family or group of families in the community as medical observers rather than medical advisers. It is believed that such programmes should be encouraged so as to produce in the future a medical practitioner public health and socially minded who can co-operate in health education activities to a greater extent.

The universal agreement that training in health education should be given to all health personnel as part of the basic professional preparation was accompanied by an equally universal recognition that this would not be easy to accomplish. Some of the factors mentioned were:

- The difficulty of trying to change years of tradition in education;
- 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 curriculum 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 exposure to health education training in their basic professional preparation.

Some concrete suggestions registered by the groups were:

Inclusion in the budget and programme of health administrations provisions for in-service training;

Recruitment of an adequate qualified staff to teach;

Integration of health education into every on-going training programme;

Publicizing successful seminars or similar meetings in the country 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 members of staff 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 bring the training to 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. Being together outside of formal situations offers opportunities for the sharing of experiences and frank discussions which help the health worker 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 with practising health workers of different disciplines, and in a different country from the one in which the course was held, the content and methods of health education of the public. This procedure stimulated health administrators to learn more about health education and gave the students experience in adapting what they had been taught to conditions in a new country.

In situations where the administrator is not convinced of the value of in-service training in health education, it would be helpful if a member of the administrative staff could attend a health education seminar. In this connexion the suggestion was
made that country could benefit from the assistance of World Health Organization experts in starting training programmes in health education. It was also suggested that the World Health Organization might 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 such highly-skilled personnel at the local level would not always be practical or possible. In general, it was stated that the health education specialist should be a highly-qualified person, who is competent and able to work on a par with programme directors and administrators as an adviser or consultant on educational matters.

The duties of the health education specialist were considered to be:

Assisting health staff and others plan and carry out the health education component of health 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 consultant 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 stated that he should be a medical doctor in order to have greater status, to be able to exert greater
influence, and be more persuasive on central administrations. Others concluded that he need not necessarily be medically qualified, and one group stated 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 all were agreed that he needed in addition an extensive training including a university education with a strong background of the life sciences, behavioural sciences, education and educational methods, including audiovisual techniques. He should have strong leadership ability, be genuinely interested in people and their problems, be warm and outgoing, 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 should be sent abroad for specialized training after some years of practical health education work in their own countries.

The World Health Organization was commended for its sponsorship of training in health education with the hope that the number of trainees each year might be increased.

Organization and Administration of Health Education 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 on a country-wide basis. A majority of the groups felt that this unit should be a part of the central health administration though some few were of the opinion that the responsibility could be carried by 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 agreed 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 one 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 health ministry and in related agencies;

Studies of 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;

Working directly with departments of education on the school health programme;

Planning for and/or developing appropriate teaching aids and health education materials;

Conducting health education demonstrations for the improvement of methods and material.

Although the exact placement of the health education unit in the organizational structure of the country would vary, it was the general consensus 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 care 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 a consultative and 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 to carry out field activities in accordance with an agreed policy.

Depending on the needs and resources of countries, the participants felt that the central unit should be staffed with health education specialists, doctors, teachers, information specialists and technical personnel in the production of materials. Sociologists, cultural anthropologists and psychologists were suggested as types of personnel to complete the health education staff.
Most groups believed that the administrator should be a physician, specialist in public health, and have a comprehensive training in health education. It was pointed out that in some countries professional health education specialists - not necessarily doctors - have been instrumental in fostering 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, 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 give service to the people and at the same time carry on health education. Others mentioned that in under-developed countries such people could make actual contact with a large mass of the population who are inaccessible to higher grade educationists. All those who felt that such 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. A cautionary note was sounded by one group. It pointed out 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 exceeding their own competencies. 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 the 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 the suggestions that came out of their discussions are:

Regular meetings or conferences at different levels, and between levels, for the exchange of views and for solving problems;
Interest by the administrative staff in the work of the health education specialist, a thorough knowledge by the administrator of what is being done in health education, and his willingness to give constructive assistance with problems;

The establishment of an organization so that the significance of health education is appreciated by the entire health department staff, and a framework in which the health education specialists and the rest of the staff can work harmoniously together.

With respect to financing the programme, the participants were all agreed that health education like all other phases of public health work seldom has enough funds to carry on as intensive activities as might be desirable. In general it was felt that provision should be made in the central organization budget for specialist services and for routine health education of the public activities. In the budgets of other divisions, such as communicable diseases control, tuberculosis, etc., 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 the unit on health education, there must be close co-operation and understanding with the special technical programme divisions concerning the development of educational material and other educational activities.

All groups mentioned the important role that voluntary health agencies play in health education of the public. As stated by one group: "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 and professional groups such as medical, nursing and pharmacists' associations, teachers, religious leaders and others.
However, groups stressed that before the full contribution to health education from these many agencies can be realized there must be co-ordination both in planning and in action. Otherwise conflict or duplication of effort will reduce the efficacy of their activities.

A variety of methods to achieve such co-ordination were described.

In some countries co-ordination is achieved by an association of voluntary agencies which, in turn, works with the official health agency. In other countries a national committee consisting of both official and non-official agencies is responsible for co-ordination. In those countries where there is a centralized and highly-organized administration for health education work, co-ordination is undertaken as one of its natural functions. In still others effective co-ordination is achieved through subsidies from the central authority to the work of the 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 executives of the agencies are more concerned with accomplishments than with credit for their agency.

Several groups considered the unique role of the press. It was pointed out that the press, over which the health authority has no control, sometimes expresses views which may be in conflict with the health authority. Two positive suggestions were made to prevent this conflict. The health administrator might hold periodic conferences with the public and the press in the development of the health programme. Also, in setting up national co-ordinating committees, the press might be represented.

STUDIES AND RESEARCH IN HEALTH EDUCATION OF THE PUBLIC

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 still unknown facts concerning human behaviour: why people behave as they do; how man thinks of his own environment; in what values does he believe; what are his aims and ultimate goals? These are some of the problems the members mentioned as needing to be clarified by research.
Groups also mentioned the need for more adequate estimates of the information people now have on various health subjects before starting health education. An example was cited of a study in a highly-developed country where it was found that 70 per cent of a sample of 14-15 years old school population did not know that pulmonary tuberculosis was a communicable disease. It had previously been assumed that this was a well-known fact.

A third type of research discussed widely by the group was evaluation studies. The types of studies mentioned included not only appraisal of the effectiveness of health programmes, but also investigation of the reason for any lack of success, or failure of people to participate in health programmes. One group pointed out that to make evaluation possible, the initial programme planning should include provision of data to form a base line and a clear statement of the problem and goals. One of the members cited an example of continuing evaluation of programme as carried out in his country. A research team 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 the base line from which to measure progress. They live in the area constantly measuring changes. This combination of research with on-going programmes has proved a valuable asset in health education work.

Another example was cited of a study to determine why people did not avail themselves of a chest X-ray to find tuberculosis when it was free of cost.

Studies to determine the effectiveness of specific methods and materials were also mentioned. Such studies would sharpen the tools of health education and increase the results from the effort expended.

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

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 the importance of the study approach. 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 note of caution about undertaking too extensive a study without expert research guidance was mentioned by one group. It cited the example of a large-scale survey concerning tuberculosis which was undertaken without the help of any social scientists. The result was most disappointing for most of the answers could not be used because the research had not been adequately planned.

The groups were sufficiently concerned about intensifying health education research to make the following suggestions to the World Health Organization:

Encourage universities to do more research in the field of health education;

Prepare a document for the use of Member countries, setting forth general guiding principles in research and containing suggestions regarding the kinds of studies needed;

Inform Member countries of the results of research already available;

Initiate studies in school health and in the evaluation of public health education programmes;

Encourage Member countries 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;

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.
The General Chairman opened the final plenary session by expressing his satisfaction with the useful contributions that participants had made in the group meetings. He called attention to the draft summary of the eleven group reports and invited comments on the four sections of the draft.

In the course of the general discussion, many of the points in the report were highlighted. Among these were the importance of detailed, specific but flexible planning of the health education aspects of any programme; the important health-education role 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 to increase greatly research efforts in health education; the responsibility of the World Health Organization to provide leadership in health-education research; the value of consultation from social scientists and the use of their research findings in public health 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 statement as developed by the Expert Committee on Training of Health Personnel in Health Education of the Public seemed satisfactory.

Tribute was paid to the Technical Discussions as a valuable tool for sharing experiences and experiments in different countries. It was also pointed out that the freedom for exchange of views within the groups under good leadership during the discussion periods resulted in much mutual education and demonstrated one health education method.
In a summary statement one of the participants made the following observations: health education is not a programme in the sense that control of a communicable disease is a programme. Rather it is a method of public health whereby the knowledge and skill of the physician, engineer, nurse and other health workers can become more readily acceptable to people who can benefit from the services these workers render. The real task of health education is to create an environment in which people can study objectively their problems and find solutions satisfying to them.

Over the years through research and experience a body of health education knowledge and skills has been developed which those who engage in health education should acquire through training. Without such knowledge and skills it is possible for health workers to secure through education the wrong behaviour rather than the correct behaviour, for the tool of education is as dangerous when used by individuals untrained in health education as is the scalpel when used by an incompetent poorly-trained surgeon.

Following a reference of the General Chairman to himself as a midwife, a tribute was paid to the value of his contributions to health education and his leadership in the Technical Discussions, with the prediction that he will henceforth be known as the Grand Old Midwife who had brought to birth new concepts and principles in health education.

After expressing appreciation to all those who contributed so extensively to making the Technical Discussions a success, 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 countries. There is no end to health education. It will continually grow and change as new discoveries are made.