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EXPERT COMMITTEE ON HEALTH EDUCATION OF THE PUBLIC

First Report

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EXPERT COMMITTEE ON HEALTH EDUCATION OF THE PUBLIC

First Session

Paris, 7-11 December 1953

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EXPERT COMMITTEE ON HEALTH EDUCATION OF THE PUBLIC

First Report *

The Fifth World Health Assembly, held in May 1952, made provision for the convening of an Expert Committee on Health Education of the Public.[1] The first session of the committee was held in Paris from 7 to 11 December 1953.

Dr. P. Dorolle, acting on behalf of the Director-General, opened the session and welcomed the members of the committee and the representatives from the United Nations Educational, Scientific and Cultural Organization (UNESCO). In his opening remarks, Dr. Dorolle stressed that health education of the public is an essential aspect of every health activity and requires the participation of all health workers in partnership with many other agencies, community groups, and individuals.

Dr. John Burton was elected Chairman of the committee ; Miss Majsa Andrell, Vice-Chairman ; and Dr. Mayhew Derryberry, Rapporteur.

1. INTRODUCTION

The first session was essentially an introductory study of health education as an aspect of health work, common to many different activities.

While realizing that the need for education exists in all countries, the committee also recognizes that there can be no standard pattern for a " health education programme " that will work everywhere.

Education in any subject must be scientifically sound and built on the current attitudes and understandings of the people to be educated. It must focus on goals which seem to them to be important, and which can

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* The Executive Board, at its fourteenth session, adopted the following resolution : The Executive Board

1. NOTES the first report of the Expert Committee on Health Education of the Public ;
2. THANKS the members of the committee for their work ; and
3. AUTHORIZES publication of the report.

(Resolution EB14.R4, *Off. Rec. Wld Hlth Org.* **57**, 2)

[1] *Off. Rec. Wld Hlth Org.* **42**, 218, 222

be realized within their capacities and resources. All these factors vary with the educational, social, economic, and cultural conditions of the different countries, and the health education must vary accordingly. It is only after a thorough study of the people, their attitudes, interests, beliefs, cultural values, wants, needs, and resources, that the most effective health education can evolve, and ultimately effect a working partnership between the people and the health programmes.

While the committee has not prescribed a standard programme, it has tried: (1) to define the objectives and scope of health education; (2) to outline the way people learn, and the role of the educator in health programmes; (3) to state broad principles of programme planning, evaluation, and organization; and to describe (4) the development and use of methods and media, and (5) the desirable training of personnel. It is felt that these principles operate universally, although the way in which they are applied will vary.

Particular emphasis is given to the importance of the learner, the "consumer" of health education. This stress results from the observations of the committee that too often in the past health education activities have relied on the wide use of educational media with insufficient consideration of the people for whom they were intended.

The committee notes with interest the frequent references made to health education of the public by previous technical expert sessions convened by WHO, and endorses the emphasis given to the need for education as a part of every aspect of the public-health programme, and to its value in the enlistment of active participation of the population in the solution of family and community health problems.

The committee wishes to express its deep appreciation to the members of the WHO Expert Advisory Panel on Health Education of the Public, and to the authors of working papers on various aspects of health education of the public, who contributed many constructive ideas and suggestions on the agenda during the period of preparatory work.

2. OBJECTIVES

The aim of health education is to help people to achieve health by their own actions and efforts. Health education begins therefore with the interest of people in improving their conditions of living, and aims at developing a sense of responsibility for their own health betterment as individuals, and as members of families, communities, or governments.

Health is but one of the elements in the general welfare of the people, and health education is only one of the factors in improving health and

social conditions. It is, however, an indispensable factor and should therefore be integrated with other social, economic, health, and educational efforts.

2.1 General purposes of health education

The general purposes of health education are :

2.1.1 *To make health a valued community asset*

The value placed on health within the culture of a community depends on many factors, such as the degree of social organization, the standard of general education, the concern the community has for its members, the number and ability of its health workers, and the economic resources of the people for family and village improvement. To enhance the importance of health in the culture, education encourages people to come together to find ways of attacking the general problems of their community, to take responsibility for doing something about them, and to obtain the help necessary for their solution.

It is recognized that the need for education in health matters is closely linked with a variety of other educational, social, and economic problems which directly or indirectly affect the level of health of the people. The first problem of concern to the community may not be directly related to health. It may be one of agriculture, transportation, irrigation, housing, or accident prevention, or of mere subsistence. Co-operation for health begins with the problem of immediate interest, assists in its solution, and then is ready to help on health problems as they become of serious concern to the community.

2.1.2 *To help individuals to become competent in and to carry on those activities they must undertake for themselves, as individuals or in small groups, in order to realize fully the state of health defined in the Constitution of the World Health Organization*

In any community, no matter what the stage of development, many health activities will have to be carried out by individuals, family members, and small groups on their own initiative and without expert help. In such activities as the successful management of child care, family feeding and food hygiene, first aid, and home hygiene, and for many aspects of environmental sanitation and emotional relationships, education is needed.

Although health rules are a part of many ancient religious and social systems, of the practices they prescribe some appear to conflict with and some to favour ideas about health based on scientific findings. In either

case, such practices and beliefs are strongly felt and may be starting-points for health education.

2.1.3 *To promote the development and proper use of health services*

The useful continuation of any health service depends on the people's understanding of its purpose, their acceptance of its value, and their active support. The use of some health services also depends on confidence of the people in the health personnel, and the attitude which health workers take towards the people. Preliminary education of the people can avoid the economic loss incurred by wrong or inadequate use of services which are often expensive.

3. SCOPE OF HEALTH EDUCATION OPPORTUNITIES

Learning about health is not limited to situations in which actual instruction is given. It results from a wide variety of experiences in the home, school, and community. Some of the situations and factors which affect health attitudes and practices are :

3.1 In the home

(*a*) The hygiene habits and practices of adults, and the guidance given to children in the formation of healthful living habits.

(*b*) The way people feel about and act towards each other as members of the family (the attitudes and behaviour of parent to parent, child to parent, and siblings to one another).

(*c*) The family attitude towards health, and the prevention and management of illness.

(*d*) The nature of the family budget, especially the priority given to such items as food, housing, and clothing.

(*e*) Sanitation of the home and its surroundings, including access to water-supplies, disposal of human wastes, refuse, and garbage.

(*f*) The production, selection, preparation, serving, and preservation of food.

(*g*) The play activities and the type of entertainment which the family chooses.

(*h*) The religious and cultural behaviour of the family.

(*i*) The quality of housing, including the acceptance or otherwise of overcrowding, lack of ventilation, etc.

3.2 In educational institutions (primary and secondary schools as well as institutes of higher learning)

(*a*) The physical environment and facilities, and the standards of cleanliness that are observed.

(*b*) Feeding practices in the institutions (school and college meals, cafeterias, snack-bars, and the like).

(*c*) The general content of the curriculum including the direct instruction in health.

(*d*) Physical education and organized games.

(*e*) Teaching methods, including the way in which rewards and punishments are used.

(*f*) Participation of children and students in community projects.

(*g*) The health behaviour of the teacher as an example to children and students.

(*h*) Human relations among all the individuals concerned (parents, teachers, and students).

(*i*) Experience with school health services, including health and growth records.[2]

(*j*) Handling of health emergencies, such as sudden illnesses, epidemics, and accidents.

(*k*) Group activities, clubs, associations, informal meetings.

3.3 In the community

Among the many community experiences that influence health behaviour are such activities as :

(*a*) Services and advice received from medical, nursing, and auxiliary health personnel.

(*b*) Participation in governmental and voluntary health programmes.

(*c*) Membership and participation in formally and informally organized groups.

(*d*) Experiences in the work situation on the farm, in the factory, or at the place of business.

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[2] The committee endorses the emphasis devoted to school health services as an educational experience in the report on the first session of the Expert Committee on School Health Services (see *Wld Hlth Org. techn. Rep. Ser.* 1951, **30**).

(*e*) Experiences at the markets, shops, and other informal meeting-places.

(*f*) Service in the Armed Forces.

(*g*) Leisure-time activities.

(*h*) Religious ceremonies and observances.

4. THE LEARNING PROCESS

If I hear it I forget,
If I see it I remember,
If I do it I know.
(Chinese aphorism)

Health education, like general education, is concerned with change in the knowledge, feelings, and behaviour of people. In its most usual form it concentrates on developing such health practices as are believed to bring about the best possible state of well-being. In order to be effective, its planning, methods, and procedures must take into consideration both the processes by which people acquire knowledge, change their feelings, and modify their behaviour, and the factors that influence such changes. The following brief description of the way in which people learn furnishes a background for programme planning in health education. The description of the learning process is not intended to be exhaustive ; it is not stated in precise psychological terminology, nor does it adhere to any particular psychological school of thought. The principles discussed are those considered most useful to health workers in their health education efforts.

4.1 Capacity for learning

Research has shown that in spite of wide differences in kinds and rates of learning, there is a capacity for significant change in ideas, attitudes, and modes of behaviour at all ages. For practical purposes this appears to hold true in all societies, and throughout the whole range of ability. All through their life-span, individuals can learn and change their behaviour to ways more satisfactory to themselves. This fact presents a challenge to health workers who are trying to help people to change their health attitudes and practices. But it does not assure that anyone will learn from an educational situation what the educator intended. What people learn depends on many factors, including the background of experience, which they, as individuals, bring to the situation.

4.2 Learning an active process

Since learning is a change in an individual's ideas and practices, this change can be brought about only through the individual's own efforts. So long as he is passive towards a situation no learning takes place. The fact that learning is an active process is of particular significance to the health educationist. He cannot assume that people learn merely because he disseminates health information. He must take into account the following factors which influence an individual's reactions.

4.3 Motivation

The forces which cause people to learn arise from within the individual and can be described as follows :

4.3.1 *Goals and interests*

The urges to satisfy certain fundamental human needs, such as survival, food, love, and social approval, are the mainsprings of human behaviour. But people strive for many other things which are no less important to them, though less vague. Their interests are seldom concerned with such abstractions as " life " and " health ", but are usually more defined, e.g., striving to prevent sickness from certain diseases, or getting along with people, or overcoming some physical handicap. People are interested in doing those things which seem to help them to achieve something they want, or to cope with their own specific personal problems.

The health education worker who recognizes this characteristic of learning will not ask " How can I motivate people to learn about health and to change their health practices ? ". Instead, he will be concerned with the goals and purposes of the people ; how he can help them to attain their goals, and perhaps to see a relationship between some of their goals and improved health practices.

4.3.2 *Group approval*

Another important force that influences what an individual will learn is the attitude of the group to which he belongs. Most individuals tend to conform with the accepted standards and sanctions of their family and friends. The tendency is to find out what is done, and then do it. Group approval or disapproval may be the determining factor in whether information is accepted, and whether any action is taken on the accepted information.

Just as it is important to recognize the wants and interests of the individual, so it is essential to understand and adapt an educational approach to the social values of the group to which he belongs.

4.4 Content of learning

The forces which cause people to learn determine what will be learned in a given situation.

Every individual is constantly being stimulated through his various senses. His responses, however, are limited at any one time. What he sees, hears, or feels, and learns, depends largely on his interests or motivations at the time. Furthermore, *what* is learned, and *how* it is learned, differs from one individual to another. Each person comes to a given situation with a unique background of experience, his own way of looking at things, and different expectations of what is to result from the situation.

A person who wants to get some service at the health centre is likely to see and read a poster indicating the centre's location and then go to the centre, whereas someone who feels no need to go to the centre may not even see the poster. A third individual, because of a previous unpleasant experience at a health centre, may see and read the poster and carefully avoid going there.

As health education programmes are developed in various countries, it is particularly important to recognize that what people of different cultures, experiences, religions, and political philosophies learn from the same educational methods and materials may be widely divergent, and far from what was intended by the educator. Therefore, the health educator must be continually on the alert to make sure that approaches or materials selected for use in an area are attuned to the value patterns of people living in that area, and developed and presented in such a manner that they can be readily adapted into the way of living of the individual.

4.5 Real-life experiences and understanding

Learning takes place more effectively when the experience has meaning for the learner and he is able to see the full implications of the experience.

This implies the need for learning in actual-life situations through real practical experiences. Actual experiences in such places as the home, the shop, the farm, or the health centre are usually much more meaningful than academic discussions or lectures about healthful practices that should be followed.

4.6 Visible paths and goals

A person will change his behaviour in a prescribed manner, i.e., learn, only when he understands what to do, and when he sees the action as a means to an end which he himself desires.

Not only must a person want to learn, but he must clearly know what action he is to take, and must realize that the action will help him to achieve something he wants or needs. This characteristic of the learning process is particularly important in health education where the information is often given in medical terms that are meaningless to the learner, or where the relationship of the advocated behaviour to the solution of the individual's problem is not readily apparent. In one area, a brief questioning of thirteen individuals, who had visited a doctor and received advice on what to do about their health, revealed that nine could not repeat the advice given. Either it was too complicated, or for some other reason they did not know what to do. Certainly in these nine cases, no constructive action could be expected.

Because the relationships between health practices and their results are frequently not readily apparent, the health educator has particular difficulty in stimulating change in health behaviour. It is not a simple task to make clear to people who have not accepted the germ theory of disease the relationship between the boiling of milk and the prevention of milk-borne diseases. Until this relationship is understood in terms of their own medical beliefs, people are not likely to carry out the practice consistently. Furthermore, the action suggested to meet a health need must not appear to an individual to be in too great a conflict with his normal way of life.

5. THE ROLE OF THE HEALTH EDUCATION WORKER

After outlining these basic characteristics of the learning process, the committee explored the role of the health education worker in facilitating learning. His goal, whether he be physician, nurse, teacher, sanitarian, or other worker, is helping to arouse interest, to develop understanding, and to foster values with which man, in given situations, can realize a healthy way of life.

5.1 Learning the ethnological characteristics of the people

To accomplish his goal, the educator should have a first-hand knowledge and appreciation of the people with whom he plans to develop a health education programme. He should be familiar with the nature of

the culture ; the way of life of the people ; their goals in life ; and their values, beliefs, traditions, customs, and taboos with respect to health and illness. He should understand the objectives for which the people are willing to strive, and, conversely, the aspects of life that mean very little to them or that they are as yet unable to understand. Such understanding of the way of life of the people is important in setting the limits of any educational effort. What are the people willing and able to accept ? What will they reject ? What are the social and economic conditions which must exist before certain innovations or educational changes can be undertaken ?

Having once learned these facts the health educationist can work with the people in planning and using educational measures which will harmonize with their life and character.

If the people believe in indigenous practitioners, be they exorcizers, magical practitioners, or secular physicians, perhaps the best method is to work with these practitioners for the education of the people. If these practitioners provide the accepted channel of communication to the people, they can be of inestimable aid in effecting the desirable changes in behaviour.

5.2 Taking account of present knowledge and beliefs

The educator should take into account the information and beliefs that people already have about health and the causes of illness. All people, including primitive cultures, have their own theories about maintaining health and curing sickness. These theories may provide feelings of as much security for those who hold them as do the explanations based on modern science. The magical systems and traditions providing this security are found among people in all areas of the world. Most individuals use these magical systems to build their own concepts of life. For example, they may believe that taking three mouthfuls of water after cleaning their teeth, sleeping on one special side, taking deep breaths on rising, and many other rituals, will exercise a direct influence on their health.

The health education worker who thinks that ignorant souls thirsting after knowledge will be glad to accept his views based on medical science is doomed to repeated failure. He underestimates the forces that maintain the processes underlying magic thinking about health. He will be unable to understand the anxieties that every individual experiences when his dearly fostered outlook on life and the world threatens to be shattered by the intrusion of other ideas.

The new system of certainties which health education offers can be accepted with good results only when it can be integrated with the existing values and concepts of the group concerned.

5.3 Mental health aspects of health education

Health education, even when concentrating on physical aspects, touches upon many subjects that involve emotional development. Instruction for expectant mothers, the nursing of new-born babies, the toilet training of the infant, are all subjects of which the psychological aspects are at least as important as the physiological. The education of the public with respect to measures of preventive medicine, such as vaccination, mass x-ray programmes or cancer control, has individual psychological and mass psychological consequences. Injudicious behaviour on the part of the educator may lead to all kinds of complications and create unnecessary anxieties. The education of the recovering patient, and his re-education in order to prevent a relapse, are charged with sentiments and fears. Health instruction at the age of puberty, preparation for marriage, advice during the climacteric period, and the special health re-orientation for aging people, are all given in psychologically precarious periods. In such phases, basic anxiety may be aroused and lead to loss of mental health.

Thus, in his daily practice, the health education worker will be confronted with many questions that have vital mental-health significance. An incorrect answer to a question from an anxious mother on toilet training may misdirect her still uncertain attitude towards her child, and encourage the development of an infantile neurosis. If not watchful, the health education worker may miss the full implications of a question asked during the biology lesson, and lose the chance to help a worrying adolescent.

5.4 Maintaining good human relationships

The importance of good human relations for any learning situation can hardly be overestimated. This involves " acceptance " of other people, no matter who or what they are ; respect for personality ; and a friendly approach based on an innate inclination to like and work with people.

6. EVALUATION IN THE DEVELOPMENT AND OPERATION OF A HEALTH EDUCATION PROGRAMME

Programme evaluation may be defined as the systematic accumulation and assessment of facts and opinions for the purpose of planning and making decisions about every phase of a programme.

Whenever a decision between alternatives is made, some evaluation is taking place, although it is often subjective and based on insufficient data

and inadequate analysis. If, however, a decision is based on a careful consideration of all the relevant facts and an impartial weighing of the evidence, then the most effective use of evaluation has been made.

It is obvious, then, that evaluation is not always " someone else's job ", someone with a specialized training. Everybody who plans any programme of action has to evaluate his decisions to the best of his ability. Nor can evaluation be carried out once and for all at the beginning or at the end of an educational programme. It must be repeated at many stages—at the beginning to ensure good planning ; during the course of the activity to allow of any adjustments or alterations which may have become necessary ; and at the end to assess the results, expected or otherwise, and to learn how future work can be improved.

To realize the maximum benefits from evaluation in the development and operation of an educational programme, it is essential during the planning to ensure that :

(1) objectives of the educational programme are clearly specified ;

(2) the criteria of success or failure are decided upon ;

(3) evaluation procedures are developed or selected ;

(4) a base-line from which to measure progress is established ; and

(5) the methods to be used are chosen and pre-tested for their effectiveness.

6.1 Determining the objectives

To make decisions about the goals of an educational programme or activity requires many facts about the people. Often health workers make their evaluation of the health needs of a community on the basis of morbidity or mortality data, but evidence is also needed on such items as :

What health needs do the people recognize and want to do something about ?

What information or beliefs do they have about the causes of their problems ?

What resources, if any, do they have for meeting their needs ?

The more objective and complete the facts obtained about such questions, the more precise will be the goals set. Although exhaustive study of such questions may not be possible, exploratory discussions with a few truly representative members of the intended beneficiaries of the programme will facilitate the selection of goals that meet the real needs of the people.

Once the main goals have been decided, it becomes necessary to break these down into specific, intermediate goals for the purpose of determining the steps and actions that will lead to desired end-results. These detailed goals help to give focus to the necessary procedures and discourage the use of hastily conceived methods.

With a comprehensive definition of objectives stated in terms of the specific changes the programme is designed to achieve, final measurement of the success of the programme becomes relatively simple. It is necessary only to ascertain the extent to which the specific changes have occurred.

6.2 Criteria of success or failure

Among the details that must be defined early are the criteria of effectiveness to be accepted.

The most realistic criterion is concrete evidence that the objective has been achieved. When the goal of the education is specific overt behaviour, such as building latrines, the criterion of effectiveness is the number and quality of latrines built. However, it is more difficult to obtain satisfactory criteria when the goal is behaviour that is repetitive and less accessible to observation, such as using the latrines built, or eating a more adequate diet ; or when the goal is behaviour that should be practised only under certain conditions, such as seeking medical care in the early stages of illness. Social scientists have constructed various methods for obtaining reliable indices of equally complex behaviour. Public-health workers can gain much help from these specialists in developing appropriate evaluation methods if they are consulted during the programme planning stages.

In developing criteria of programme success when concrete evidence is difficult to obtain, the temptation must be avoided to use easy-to-get data which actually have no valid relation to the goal set, such as the number and kinds of educational activities performed by public-health workers. A review of the general success of a programme has value in so far as it is expressed in terms of specific objectives achieved.

6.3 Development of evaluation procedures

The criteria decided upon to judge effectiveness will determine to a large degree the evaluation procedures to be used. In point of time, these should be determined along with the decision about educational activities in the programme. Choice of the appropriate evaluation procedures while planning the educational programme will increase the likelihood

that an adequate base-line from which to measure change can, and will be, obtained. It will also assure that the changes being evaluated are those originally intended and not some unanticipated changes, however desirable, that may have occurred.

6.4 Establishment of base-line

Another essential to the evaluation of educational activities is the establishment of a base-line against which to measure progress.

Frequently, a sufficiently accurate base-line of the knowledge, attitudes, and behaviour of the people is not obtained. Such oversight seriously hampers subsequent evaluation efforts. Various procedures have at times been used in appraising programmes when an adequate base-line was not available. One procedure is to describe the health knowledge, attitudes, or behaviour after the programme is in operation, with the implication that the programme has produced change. Since the previous state is unknown, such conclusions may be grossly misleading.

Another unsatisfactory procedure is to compare the progress of those in the programme with a different group that has not been exposed to the same programme. Such comparisons assume similarity of the two groups at the beginning, and fail to take into account the many forces outside the programme that may influence the results. Furthermore, comparison with other groups does not yield the most productive data for programme improvement, for its main focus is on the differences between the groups, and not on the educational accomplishments of the programme.

6.5 Selection and pre-testing of methods

The selection and pre-testing of methods involve a number of factors and are considered in section 7.

6.6 Summary

Once the objectives have been clearly defined, criteria and techniques for measuring achievement decided upon, an adequate base-line established, and the methods selected and pre-tested, evaluation of the educational programme at periodic intervals should reveal the places where progress has or has not been made and indicate the reasons for success or failure. Steps can then be taken to replan the programme, adopt new procedures, and improve the effectiveness of the educational effort. Only through such continuous revision can the goals of health education of the public be most effectively realized.

7. GUIDING PRINCIPLES IN PLANNING AND IMPLEMENTING HEALTH EDUCATION ACTIVITIES

The committee recognizes that there are wide variations in the organization and administration of health programmes in different countries. In addition, account must be taken of a multitude of social, cultural, and economic factors which vary from country to country, and even within the country or district where health education measures are to be applied. Accordingly, there can be no single formula as to how and where the health education activities fit into the whole public-health strategy at various administrative levels.

The following factors and broad principles are considered important :

7.1 Integration in health projects

Planning for health education should be an integral part of all health planning. The success of any programme for health improvement, such as the installation of a safe water-supply, or a mosquito-control, a nutrition, or an immunization programme, depends on the understanding and co-operation of the people. Plans for the education necessary to ensure this understanding and participation should be made along with all the other details.

7.2 Preliminary survey

A well-planned programme requires consideration of what has been done, what needs to be done, what the people want to be done, how it is to be done, the capacity to finance the programme, and the adaptation of the existing resources to the new plans.

7.3 Study of the people

As previously indicated, careful study is required of the cultural characteristics of any given group in its environment. Ethnological studies, and the collaboration of anthropologists in the orientation, planning, and conduct of health education, are always helpful, and are essential in technically less developed areas.

7.4 Planning with the people

The interests, needs, and aspirations of the people themselves provide the starting-points and motivating forces for enlisting their goodwill and

participation in planning and action. The people for whom programmes are being designed should take part in the planning from the beginning, thus ensuring planning *with* rather than *for* the people.

Many examples can be found where ready-made educational plans, superimposed by outsiders without consultation with the people concerned, have failed. Such failures have often been ascribed to indifference or resistance instead of to the actual failure on the part of the planners to make clear to the people what they were expected to do, and the reason why.

7.5 Survey of personnel and resources

In deciding the educational methods and approaches, the contribution which personnel, at all levels, in the health team and in other spheres might make should be explored. The resources and facilities available should also be reviewed, so that full and appropriate use can be made of all opportunities.

7.6 Value of local leaders

Planning should note carefully all existing leadership elements in any given locality. It is important in all areas to enlist the goodwill and participation of the natural leaders and personalities who have some influence among the people. In the more technically developed areas it may be possible to utilize the skills of many trained workers. In other areas, these leaders may be religious healers, magicians, witch-doctors, chiefs, or elders in whom the population has a high degree of trust and confidence.

7.7 Co-operation of local medical practitioners

There is an important connexion between curative medicine and health education programmes. Hence, in areas where medical personnel exist, it is of the utmost importance to enlist the co-operation of the medical profession, taking into account the following questions:

(1) What are the medical practitioners' points of view on the measures which need to be taken, and on their own capacity to do educational work?

(2) What is the capacity of the medical services in terms of facilities and personnel to meet the needs and demands which may be created through health education of the public?

7.8 Co-operation of other agencies

Programme planning at all stages should involve the co-operation of leaders and personnel, at all levels, of official and voluntary health and other agencies, in order to utilize all ways of reaching the total population, and to prevent unnecessary duplication of effort and expense.

Co-operative effort between official health and education authorities and leaders of teacher-training institutions and colleges is felt to be of particular significance, since the school programme is one of the important focal points for health education. It is desirable that the family and community support the school efforts, so that the health attitudes and practices taught in school may be reinforced rather than weakened by experiences elsewhere.

A most important contribution can be made to joint educational effort through the collaboration of various agricultural institutions, religious institutions, adult education services, industrial programmes, citizens' committees, civic organizations, co-operatives, and all movements pursuing common educational aims for human betterment and improved standards of living.

7.9 The focal point

The important focal point in all educational programmes is the local situation. Here, local officials, health and education workers, and the people, can work together in the planning, adaptation, and execution of programmes in accordance with local needs, circumstances, and resources.

7.10 Pilot studies

In the development of a health education programme for an entire country or region, it would seem desirable in the beginning to foster local educational experiments and demonstrations based on the preliminary studies already described. From such pilot projects should emerge experiences useful in other parts of the country faced with comparable problems and circumstances.

Experience has shown that it is wise to start with simple educational measures most likely to succeed, and then move on to further activities when success has been achieved and the confidence of the people secured.

7.11 Team-work

Effective health education requires close team-work among the many categories of health and education personnel. Such team-work implies

the planning and organization of health education programmes so that each person accepts responsibility for that part of the programme he can do best, and carries out his part in such a manner that it supports the work of all the other personnel.

7.12 Health personnel as education workers

It is essential that all health workers be trained to make the best possible use of all health education opportunities and to possess both knowledge and skills in the use of educational methods, approaches, and media. In this respect, particular attention is drawn to the important role of physicians, nurses, medical-social and social workers, environmental sanitation personnel, nutritionists, midwives, teachers, and other education workers.

7.13 Role of the professional health education specialist

To give effect to systematic planning and sustained implementation of health education, it is essential that the responsible authorities have at their disposal the services of qualified professional workers with special training and competence in health education of the public.

The success of the agriculture extension worker has shown how effective a scientific training in agriculture combined with a training in education and social sciences can be in helping people to improve their traditional methods of agriculture. The problem in the field of health is essentially the same, and much could be accomplished by a similar training, i.e., a training including social science, education, and public health.

7.14 Financial provision

The life-line of the health education programme, as of any health activity, is the availability of funds with which to finance it. Provision of funds may be made from official or voluntary sources at the national, provincial, or local levels. Contributions from local sources in accordance with the means available tend to foster a sense of local responsibility and ownership.

7.15 Priorities in spending

The committee notes that there is frequently a lack of balance between the relatively large amounts of money spent on the production of costly media and materials, such as films and exhibits, and the funds allocated

for other important aspects of a balanced educational programme. Attention is drawn, for example, to the importance of placing high priority on the establishment of training courses in health education of the public for professional health workers, educationists, auxiliary personnel, voluntary community workers, and others. Ultimate success depends on the availability and quality of the personnel trained to carry out health education functions and responsibilities.

7.16 Evaluation

The importance of evaluation as an essential part of the planning, organization, and execution of health education programmes has already been discussed, and is again emphasized.

8. GUIDING PRINCIPLES IN THE SELECTION AND USE OF THE METHODS AND MEDIA [3] OF HEALTH EDUCATION

There is as yet very little scientific knowledge about the effectiveness of any of the methods or media used in health education, because sufficient research has not yet been done. The health education worker should therefore preserve an experimental attitude to his tools, so that he can be flexible in using them, and critical of their appropriateness.

METHODS

Most methods of education belong to one or other of two main types :

(1) One-way or didactic methods, based on the direct instruction of an individual or group of individuals ; *or*

(2) Two-way or Socratic methods, based on the interchange of knowledge between two or more people.

8.1 One-way or didactic methods

These methods (which include lectures, films, leaflets, posters, radio, television, advertisements, and newspaper articles) assume that the learner is a more or less empty vessel into which information is poured, and that he will then integrate, interpret, reproduce, or act upon this information at some later date.

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[3] The " method " describes the general way of carrying out a project : the system of procedure ; the " media " are the particular means of communication employed in the method.

Often very little is known about his existing knowledge, reactions, or interpretation of the information. For such methods to be effective, therefore, every effort must be made to present the facts from many points of view and through as many senses as possible. Even so, the effectiveness will probably be low.

8.2 Two-way or Socratic methods

These methods assume that people already possess information, feelings, interests, and beliefs which profoundly influence the learning process, and which must be taken into account before they can be modified or even left alone. Here, two or more people, with different backgrounds of knowledge, work together on the information, integrating it with existing ideas and with possible action.

Such methods of education (which include discussions, committees, councils, interviews, drama, projects, " live " demonstrations, and contrived situations) demand more in time and effort from those participating, but are generally agreed to be more effective in overcoming resistance and in promoting action.

These methods are concerned less with direct teaching than with creating situations where people learn by experience, by taking part in some activity, either intellectual, manual, or administrative, with preferably some informed leader at hand to help out wherever necessary. The committee calling in a consultant, schoolchildren asking questions during a visit to the health department, the health visitor discussing with a mother how she is going to feed her baby, or the sanitarian actually working with the local people, are some examples of this approach.

Free group discussions are particularly effective as the participants can provide information and gain knowledge in many different ways, and have the opportunity to ask questions, to contribute ideas, and to clear their minds. Moreover, a discussion group is in itself a new group to which the individual can feel he belongs and from which he can get courage and protection.

Both types of approach, didactic and Socratic, can often be used concurrently or consecutively with good effect.

8.3 Selection of methods

In the selection of educational methods to be used, objective evidence is needed on such questions as the following:

Is the action proposed physically and economically possible for the people ?

What are the relevant traditional habits of the people ?

Can a method of achieving the health goal be found that will fit in with these habits ? If not, what method will be least disturbing ?

What are the usual channels of communication in which people have confidence ?

Does the method make maximum use of this means of reaching the people ?

Who are the leaders in the community, and how do they influence the behaviour of the people ?

What educational method or procedure will fit in with the leaders' normal functions ?

What are the religious and cultural traditions with reference to the specific problem ?

Does the method or the solution proposed conflict with strong social influences on the people's behaviour, and if so, can they be modified to minimize such conflict ?

Time spent in accumulating objective data on these and similar questions through discussion with the people will prevent the selection of ineffective or offensive educational methods and will be well repaid later.

8.4 Criteria of effectiveness

It is the committee's opinion that in practice the selection of methods should depend on the degree to which they meet the following criteria :

Will the methods assure that the information will actually reach each individual ?

Will the methods attract and hold the interest of the people ?

Will the methods assure that the content and purpose of the new ideas are understood ?

Will the methods be seen by the people as a means to an important goal ?

Will the methods assure active participation of the people ?

8.4.1 *Reaching the people*

The first three criteria concern the problem of reaching the people physically, intellectually, and emotionally, and involve the consideration of many details.

How many and what kind of classes, visitors, meetings, transport, accommodation, pamphlets, etc., will be required to implement the programme ?

What times, places, and costs are suitable and convenient ?

Have the varying intelligence and literacy ranges been met ?

Are the media and vocabulary acceptable ?

Does the method promote feeling as well as knowledge ?

Does it provide opportunity for the feelings of the people, both positive and negative, to be expressed, and for the anxieties, so often the result of medical information, to be ventilated and overcome ?

8.4.2 *Participation by the people*

The extent to which members of the community will participate depends to a considerable extent on self-interest. Will taking part seem to help each to achieve something he wants ? The latent talents of the people can be engaged not only in carrying out the desired action, but also in planning the methods and preparation of the media. When methods and media are " home-made " they have the advantage of being " tailor-made " for the locality. Also, the interest aroused, and the skill and experience in doing things for themselves so gained, are most valuable educational experiences for the people involved, and well worth any extra time spent.

Only those methods in which the greatest number of people with different interests and skills can find some satisfaction should be chosen.

" Clean food " guilds of traders, employees, and housewives, malaria-control teams, health-and-safety committees in industry, " projects " in schools, and co-operative enterprises in agriculture and food production, all encourage the co-operation of many different people. Participation of the people in the choice of methods to be used also helps to ensure that the programme itself is likely to meet with approval and to be within the resources of the community to carry out.

8.4.3 *Participation of health workers*

Participation of the health workers in the selection of methods is equally important. The personal element in health education is so great that it is imperative that all levels of the health personnel must understand and agree about the methods to be used. The administrator of the health programme should consider such questions as the following :

Have the field health workers taken any part in selecting the method ?

Do they believe in it and can they, with or without further training, operate it effectively ?

Does the method provide for personal contact between health workers and the public ?

Does the method provide for regular consultation with field workers, and does it lend itself to modification in the light of experience ?

How experienced and skilled are the health workers in making good personal relationships with members of the public ? (Without this, the most carefully selected and planned method is likely to fail.)

8.5 Scope of method

One further principle is also important in the choice of methods, and it is more likely to be fulfilled if the people participate early in the planning. It is best to select a method which can start small, and the limitations of which are recognized. The programme should never, because of lack of personnel and the vastness of the task, depend solely on costly and impersonal didactic methods, such as sending out film shows and exhibitions, putting up large numbers of posters, or newspaper publicity. The extent of the task undertaken should be limited to such a size that a balance of Socratic and didactic methods can be achieved, which in practice often means a balance between the employment of health workers and the production of materials.

8.6 Pre-testing

Once the educational methods have been selected, it is possible to pre-test them, to eliminate anything that may prevent the programme from being effective. While satisfactory pre-testing does not assure programme success, it will make success much more likely. Such tests can be carried out with a small number of people with very little time and cost.

MEDIA

In discussing the selection of health education media the committee stresses the importance of considering :

(1) costs of production ;
(2) facilities for local production ;
(3) human resources available to produce and use them.

8.7 Costs of production

There is no evidence that costly media of health education are more effective than cheap ones ; in fact they usually have the serious disadvantage

that their cost precludes them from being locally produced. Though locally produced material sometimes suffers from inexpert "finish", it can be topical and comprehensible in terms of vocabulary and design to a unique degree.

8.8 Facilities for local production

The need to produce locally very often reveals a quite unsuspected wealth of talent which adds greatly to the human resources and self-sufficiency of any community.

The art of giving talks, or of story telling (in which so many cultures are already so rich), and of leading discussions, are media of communication which are already present and which can be cultivated at little cost. And there are few communities without an artist or an actor whose skills can be used and developed. But if technique and artistry overshadow the message they are designed to convey, or the standards set are so high that the amateur feels inadequate, perfection can become the enemy of the good.

8.9 Choice of media

The effectiveness of media in health education depends on many factors, and the educator should ask himself what combination of media will make the learning experience most complete and closest to first-hand experience.

The educator will select media which appeal to as many senses as possible —vision, hearing, touch, etc.—and which give the best appreciation of the behaviour of the things being studied, and of the reason for the behaviour. He will try to use media which link the new knowledge to knowledge already possessed, and he will provide opportunity for practice, both in the new ways of thinking and in the new behaviour.

Ideally he will choose reality first—handling a baby is learnt by handling a baby—adding a rational basis for what is recommended, and providing supervised practice. Such learning is best carried out in the family or clinic group, with the actual utensils or materials used by the people themselves. If this is not possible then various substitutes which approximate as closely as possible to reality can be used. If models of unfamiliar objects are shown they should be to scale and correctly coloured. If they are to be copied and used by the people they should be made of local, easily procurable materials, e.g., a home-made food-safe of bamboo and mosquito netting is much more likely to be adopted than one bought from

the town. If movement or behaviour is an essential part of the experience, moving models or a moving picture may be used. Symbolic representations, such as cartoons, isotypes, drawings, flannelgraphs, may also be used. For explaining complex processes symbolized and simplified versions may be more valuable.

The committee, however, recognizes that materials do not necessarily speak for themselves, and a programme of public health which consists mainly of the production of material is comparable to a school system which provides children with books but no teachers.

8.10 Personal factors

The other factors of importance, then, in this question of media are the human ones.

Does the medium selected enable the learner to be a partner in the learning process ?

Does it involve him in making choices and taking decisions for himself ?

Does it appeal to his aesthetic sense, or to his emotions ?

Is it likely to create resistances which will block learning ?

More detailed reference to methods and media is included in the Annex (see page 35).

9. TRAINING IN HEALTH EDUCATION OF THE PUBLIC

The committee considers that the establishment of training facilities in health education of the public is of the greatest importance in developing the educational skills and competence of professional health personnel, educationists, auxiliary workers, and socially-minded voluntary leaders.

9.1 Preparation of professional health personnel

Every contact the public has with health workers is a learning situation, which may be positive or negative in effect. To help to make these contacts beneficial it is essential to make provision in the training of all health workers for the study of the principles of and practical experience in, health education and working with people. Health workers need to appreciate the importance of attitudes, beliefs, and value systems of people, and the reasons underlying their resistances to learning. They must also have the necessary educational skills to assist people in handling their health problems, according to the best scientific knowledge available.

The personality and emotional maturity of health education workers are of paramount importance, and should be deciding factors in their selection for training in this work. The authoritative person, so often a good lecturer or organizer, may not be the best one at drawing out the dormant skills and self-reliance of people, and on these the successful continuance of a programme must ultimately depend.

9.1.1 *Basic training*

As pointed out in the second report of the Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel, " all of the sciences familiar in medical study must contribute to an understanding of the living person as a growing, developing, and maturing organism in an active and living environment ".[4]

Early in the course of studies there should also be an introduction to social concepts, contact with people in various social environments (including future co-workers in parallel professions), and practical experience of community health-protection programmes.

In many countries it is assumed that the nurse and the medical-social worker are teachers of health. This idea, however, is still not recognized everywhere. The committee draws attention to the opinion expressed at the second session of the Expert Committee on Nursing : " The nurse is a teacher of health. She goes into the homes of the people to teach both the prevention of disease and its cure ; she teaches the patient in hospital the nature of his illness, in language he can understand, so that he may endure it, co-operate in his own cure, and learn how to avoid becoming ill again. All nursing personnel have a moral obligation to the community to teach the prevention of illness. " [5] Therefore, it is suggested that the basic programmes of schools of nursing should be designed to prepare nurses for their educational functions and responsibilities.

The need to include some instruction in health education in the training of doctors, nurses, sanitarians, midwives, social workers, nutritionists, and workers in related health disciplines, is increasingly urgent. The addition of a training in health education of the public to that given in hygiene and preventive medicine to medical students would be of particular value.

9.1.2 *Role of the hospital*

Attention is drawn to the health education role of the hospital which is a training ground for many health workers. Patients are often eager

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[4] *Wld Hlth Org. techn. Rep. Ser.* 1953, **69**, 9

[5] *Wld Hlth Org. techn. Rep. Ser.* 1952, **49**, 8 (section 2.4.1)

to learn what will help them to regain health, and the hospital affords many opportunities and resources for training and practice in health education of the public.

9.1.3 *Post-graduate training*

In the post-graduate training of doctors, public-health nurses, environmental sanitation personnel, and other public-health workers, health education should take a leading place, as the development of public health is making this an increasingly important part of their work. Post-graduate training resources, such as institutes or schools of public health, provide a valuable focal point for group training of public-health workers in the principles and procedures of health education of the public.

The committee endorses the recommendation made at the first session of the Expert Committee on Professional and Technical Education of Medicine and Auxiliary Personnel that health education of the public be included in the public-health training of professional and ancillary members of a comprehensive public-health team.[6]

9.1.4 *In-service training*

It is felt that in-service training programmes afford another very important means of developing the health education skills and capacities of professional health personnel, auxiliary workers, and workers in related disciplines. Continuing staff-education programmes, group conferences, seminars, practical field experiences with competent technical guidance, periodic meetings, and specially planned study-groups and courses, can be of great value in bringing knowledge up to date, and in fostering educational skills and the application of methods most suitable to the local conditions and needs.

9.2 Preparation of professional specialists in health education of the public

There is a wide variety of health educators with specialized training for different responsibilities. For example, some may be working nationally, provincially, or locally in public-health programmes administered by official health agencies, or by voluntary health organizations. Others may be employed in colleges, universities, or schools.

The principal functions of the professional health education specialist are to strengthen and extend the educational functions of all members of the health team, and to supplement their health education activities

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[6] *Wld Hlth Org. techn. Rep. Ser.* 1950, **22**, 13

on a sustained and organized basis. The qualified health educator contributes to the health team a fundamental understanding of the basic social sciences, just as other members of the team—the doctor, nurse, sanitary engineer, and others—bring their particular skills to the solution of health problems. More specifically, the functions of the health education specialist may include : helping to create interest in, and definite opportunities for people to learn about, health matters ; taking part in studies of community problems or resources, and of means of reaching the people ; assisting in the enlistment of the active co-operation of the people, and in fostering co-operative relationships with health services and related agencies ; assisting in the selection, development, and use of educational methods and media in accordance with local needs and possibilities ; helping to plan and conduct training programmes in health education for health workers, school personnel, and staff members of other relevant agencies ; explaining the health services which are available to the population ; and helping to evaluate health education aspects of the total health programme.

The committee recognizes that the training of personnel for these functions would vary according to the needs of the countries. In general it is agreed that the training of professional health education specialists should add to a good background of general culture the following subjects :

biological and physical sciences ;
basic social sciences ;
education and educational psychology ;
hygiene and public health ;
special skills required in health education ;
public administration.

The committee feels that carefully planned and supervised field and apprentice experiences should be regarded as important elements in the training of the specialist in health education, so that he may develop skill and ability in the actual performance of health education.

Above all, the health educator must be adaptable, sensitive to the needs of individuals and groups, and have skill and tact in dealing and communicating with them. The mental health aspect is of special importance with respect to the training and supervision of health educators. Training experience may be of decisive significance in developing good working relationships with people. The atmosphere of the organization in which the health educator works, and the character of the supervision, may help the natural assets of a well-adjusted personality to thrive.

9.3 Preparation of auxiliary workers

The committee is aware that, in many countries, workers designated as " auxiliary health educators " receive inadequate preparation. Moreover, auxiliary workers in health education are often given responsibilities far beyond their knowledge and skills. It is unrealistic, however, to disregard the fact that auxiliary workers in health education are required in some countries. It is suggested that consideration be given to providing continuing training of these workers to keep them abreast of new developments and to increase their competence.

Particular attention is drawn to the importance of providing adequate guidance and supervision of auxiliary personnel engaged in health education of the public. The expansion in the number of auxiliary workers should be related to the availability of trained personnel to provide sound technical supervision and counselling. The committee believes it would be of value to encourage careful studies of programme requirements to determine the needs for personnel in health education, and to co-ordinate planning with the full utilization of all existing public-health and education personnel.

9.4 Preparation of school personnel

For the school to make its maximum contribution to health, administrators and teachers should know the potentialities for health education in various school situations, and the sources of accurate health information upon which they can draw.

It is particularly important for the school administrator to have training in health education, for once he understands that health education involves instruction, environment, and services, and is not just a subject to be taught, realistic and effective health education in the school programme can result.

If the teacher is to fulfil satisfactorily his responsibility for health teaching and guidance he should have training in health education as a part of his basic preparation.

The committee notes that the first session of the Expert Committee on School Health Services drew attention to the fact that there are many teachers now working who have not received adequate preparation in subject matter and methods for teaching health. It strongly endorses the proposal that " instruction must be specially planned through vacation courses, conferences, institutes, and seminars, in close co-operation with

public-health agencies, unofficial health groups, medical and nursing resources, and other pertinent groups ".[7]

Public-health and education agencies can help to advance health education by preparing qualified leaders to train teachers for their health education responsibilities.

The co-operative relationships of the school personnel and community public-health workers, and the value of working together as members of a team, should be experienced by the student teacher while still in college. Through such experience will come understanding of the contributions made by the administrator, teacher, doctor, nurse, and other workers, and mutual respect for the particular skills and limitations of each.

Teachers should also be encouraged to use as subjects for study the problems of real life in the home and community of interest to children at different levels of growth and development. This emphasis on practical problems and knowledge of local resources and services will enable teachers to adapt health teaching to the local situation.

The committee endorses the views expressed by the Expert Committee on School Health Services with regard to the conduct of health education in school programmes.[8]

9.5 Preparation of voluntary leaders

The committee recognizes the valuable contribution which can be made voluntarily by socially-minded persons who become interested in health problems. It is particularly important that they also participate in a co-ordinated training programme, so that their influence among the people who have confidence in them is based on accurate scientific knowledge, and is used wisely.

10. WHO PROGRAMME FOR HEALTH EDUCATION OF THE PUBLIC

10.1 Programme priorities

The committee notes with satisfaction the developments in health education which have been undertaken by the World Health Organization in co-operation with Member States, and draws particular attention to the importance and value of: (1) multi-professional regional and national

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[7] *Wld Hlth Org. techn. Rep. Ser.* 1951, **30**, 32 (section 4.3.3)

[8] *Wld Hlth Org. techn. Rep. Ser.* 1951, **30**, 16 (section 3.2.9)

seminars and conferences; (2) co-operation with interested governments in strengthening training programmes in this field for professional, technical, and auxiliary health workers, and educationists; (3) fellowship aid for training professional workers in health education of the public; and (4) assignment of health educators to selected demonstration training programmes.

10.2 Co-operation with international organizations

The committee wishes to mention the value of collaboration with other organizations, particularly with UNESCO, in the national and international training programmes in fundamental education in which WHO is co-operating, along with the United Nations and the other specialized agencies.

11. FURTHER STUDIES

The committee recognizes that the future progress of health education of the public will depend on the training of personnel, on the interest, understanding, and support of official authorities and voluntary organizations, and on the financial resources which will be made available. Future progress will depend equally, it is thought, on the attention given to implementing carefully-planned field studies, research, and experimental programmes in this field. To date, comparatively few studies and field experiments have been carried out, and the methods and procedures used have therefore been based on experiences in other fields.

Although the mental attitudes and dietary patterns of people have been the object of innumerable studies, the attitudes and beliefs of people as regards disease and health have not been studied methodically to any extent. Comparative studies carried out among different cultural groups would provide a basis for determining the educational methods and approaches most suitable to differing conditions and circumstances. In the future it should be possible to have a choice of methods based on careful analysis of the findings and experiences of a large number of health educationists.

Experience has also shown that people often fail to understand the real meaning of the medical advice given to them. Some controlled studies could reveal what educational factors contribute to success or failure in this respect.

It is not possible in the present report to examine thoroughly all the aspects of health education of the public which merit further study. The committee wishes to propose therefore that the following subjects be

considered by technical study-groups, or by reference to future committees, or by conferences convened by the World Health Organization on its own or in collaboration with other relevant specialized agencies and organizations :

(1) It is recommended that a technical conference or study-group be convened to delineate the areas of health education of the public where the need for stimulating studies and experimental programmes seems to be particularly urgent. This study could include examination of known methods and the means of fostering closer collaboration between health educationists and other social science specialists.

(2) Recognizing the important role of the schools and educational institutions in health education, the committee recommends that, in collaboration with UNESCO, a joint study-group or conference be convened to explore the question of fostering training programmes in health education in teacher-training institutions, colleges, and universities.

The committee considers that additional subjects which merit attention include study of (1) the needs and training requirements for professional specialists and auxiliary workers in health education of the public ; (2) the role of the clinician in health education ; and (3) health education requirements among groups with special problems, such as maladjusted or handicapped children.

12. SUMMARY

The committee considers this report as an introductory review of the main problems involved in strengthening and developing health education of the public as an integral part of all health activities. No attempt is made to study the details of the subject. Attention is devoted chiefly to broad guiding principles about the way people learn, and of planning, organization, and evaluation ; to the factors involved in selection, development, and use of methods and media ; and to the training of personnel for their responsibilities in health education of the public.

The committee has recognized throughout its discussions the prime necessity for enlisting the goodwill and participation of the people, since health education of the public always involves working *with* people whatever the circumstances may be.

The committee wishes to underline its recognition of the important contribution being made to health education of the public throughout the world by existing health workers, educationists, and the many others, who are helping people to achieve a higher level of physical, mental, and social well-being.

Annex

SELECTED ILLUSTRATIONS OF METHODS AND MEDIA

Methods

The *spoken word* is still the most universal medium of communication.

The *interview* is most suitable where an individual has a definite problem to which he wants a solution, e.g., a medical consultation. Where a first contact is being made between the public-health service and a citizen, or where a highly-resistant individual refuses to take part in any group activity, the interview may be essential.

Talks, lectures, and panel discussions are common methods of giving information. Their main value is to present a subject (topic) to large numbers of people. Most speakers agree that very few points of a lecture can be retained by a general audience, that few audiences can fix attention for more than short periods of time, and that the effect a lecture produces depends on dramatic qualities in the personality and performance of the lecturer, and fades rapidly.

In the interrupted lecture, which may last from one to one and a half hours, the speaker designs his talk for breaks at suitable intervals to allow for questions and discussion. The audience may be asked to form small groups and discuss a point for a few minutes, after which a spokesman gives the general opinion of his group.

In one type, the panel discussion, a small number of people sit on the platform with the chairman. Each presents the case from his own point of view in a five- or seven-minute talk, and finally the panel discusses. The audience may be invited to join in at this stage.

The main purpose of these methods of presentation is to add variety of approach, and to break up the periods for which the audience has to focus attention.

Discussion groups. A discussion group may consist of a variable number of people, from five up to about 20, who have come together to study a question, to determine a policy, or to enjoy the exchange of ideas. Such groups include study circles, religious groups, youth groups, trade union groups, mothers' groups, or professional training groups.

Successful group discussion can be the most complete of those methods which rely principally on communication through the spoken word. It enables each member of the group to hear facts, errors, distortions, and

examples, from many points of view as well as his own; and to experience his own feelings about the information, and express himself about the subject. It provides the opportunity for action to be planned and approved by the group, thus providing strength and security for each member involved in changing customary habits.

Media

Aids to the spoken word

The three methods described can be rendered more effective by the use of visual aids, such as real-life demonstrations, models, and pictures, either static, mobile, or moving.

Demonstrations and models. Real-life demonstrations, involving visits to installations such as good houses, pasteurizing plants, and properly constructed wells, talking to the people who use them, or joining in their actual construction, are effective teaching experiences. As it is not always practicable to visit the real thing, the demonstration of models or their construction can be tried as a substitute.

Still pictures and film-strips. Among low-cost media particular attention should be directed to the value of still pictures which may be specially produced, or can be found in many illustrated magazines. Film-strips, which are a series of still pictures on film, are a more convenient form of lantern slide. Being projected, they have the advantage over other pictures in that they can be used with bigger audiences. Ideally, the pictures should be self-explanatory photographs or drawings without captions, as they are more flexible in the hands of a teacher and do not commit him to the views of the producer.

It is also possible to provide a sound accompaniment, recorded on gramophone records and synchronized with the film-strip by a sound signal. Sound film-strips, because of the continuity of the sound element, create the illusion of movement in the pictures and possess great dramatic reality. For this reason a human problem or case-study realized through a sound film-strip is a most effective way of presenting a situation to a discussion group.

Mobile pictures : flannelgraph and magnetic blackboard. The flannelgraph is a picture, the parts of which are movable. The background consists of a sheet of flannel thrown over a board, to which the illustrations, backed with lint, adhere easily. The picture is built up gradually and only the object with which the speaker is dealing is shown. The parts may then be moved to display different relationships. The parts may be affixed by the speaker, or by the audience. For instance, if it is desired to teach

food storage, the audience may be given a choice to make. Three alternative methods of storage may be suggested—such as refrigerator, larder, and cupboard—representing three temperature grades. These are then mounted at the head of three columns on the board. Pictures representing common foods are then handed to the audience who are asked to store them. When they have made their choice, discussion follows on the correctness or otherwise of the selection; each item is considered, and the reasons for its placing criticized or approved. The effect is to focus attention and to promote thought and criticism. At the same time the discussion ends by registering a group decision.

Such multiple-choice situations may be created to deal with problems in many spheres, such as personal hygiene, nutrition, sanitation, and administration.

The film and television. Programmes, whether features or documentary, are generally produced as self-contained media, using the spoken word and the moving picture. As didactic media they have considerable authority and power to serve very large audiences, and to stir them. Next to live demonstration they are the only media which present movement or behaviour authentically, and in cases where demonstration is impossible, owing to the speed or extent of the movement, they can slow down or speed up, or cover distances in a way impossible with any other medium. They can tell a story and create an atmosphere very effectively, but because of their completeness and authority they produce a passive state in the audience. Their disadvantages are largely due to cost. The cost of films generally precludes their production for a small local or economically poor community. All too frequently films are used which portray customs and values quite foreign to the area in which they are shown, involving all the disadvantages of cultural domination by the technically advanced producing countries. Although this applies more to feature films, it is striking how often documentary, instructional, and training films are rendered unusable because of this factor.

In some situations it is inconvenient to have both film and film-strip projection facilities. In such cases the still film-strip pictures may be photographed on moving film and projected with a sound accompaniment.

Drama, role-playing, and story-telling may be very effectively used in health education, and many plays and playlets have been written for such diverse purposes as health procedures for servicemen, or demonstrating the right and wrong ways of interview. Role-playing in which the individual takes the part of some other character is often a valuable experience in understanding other people's jobs or problems, and in giving the health educationist greater insight.

The written word. Correspondence by letter is another method of communication for which every health education programme should try to cater. Letters to the press, particularly the local press, are also a good method of provoking discussion on health matters and of bringing together interested people who wish to work on some project. The popular press realizes the interest which exists in health matters and normally devotes much advertising and other space to the " attributes " of health. Articles of general interest, if well written and accurate, will often be accepted by editors. The health educationist should also have a policy for dealing with press inquiries, as it is of great importance to any public-health programme that there should be a friendly and well-informed press.

Leaflets and pamphlets have two main functions:

(1) to familiarize rapidly a large number of people with some new or recurrent theme, such as diphtheria immunization or water precautions;

(2) to follow and reinforce advice given by word of mouth.

Such publications should be short, illustrated if possible, attractively presented, and cheaply produced. It should be recognized that few will be kept, and that the impact must be achieved on first reading. Before preparation, it should be decided exactly for whom the pamphlet is designed and exactly what idea it is intended to convey. The draft should then be tested on some of the people for whom it is intended and their comments noted. Any ambiguities in the text or illustrations can thus be removed.

Posters are intended to attract attention rapidly to a single word or idea. They are designed to familiarize by continual repetition, but they should be used sparingly and for a definite purpose (never just for decoration), and should be changed frequently, or their impact will be lost.

Booklets are particularly useful for topics in which there is a high degree of public interest, such as baby care.

Health Exhibitions. Health exhibitions have two definite functions in a programme of health education. If properly organized and publicized they attract large numbers of people who might otherwise never come in contact with a variety of new ideas on health matters. On the other hand, their organization can draw into activity numerous people, such as the editor of the local newspaper, artists, photographers, school-teachers, tradespeople, secretaries of local organizations, and other prominent citizens, who might not normally come into contact with the health department's activities. The opening ceremony provides an occasion for higher officials to appear and declare policies.

There is a tendency for all concerned to relapse into inactivity when the exhibition is over. Planning beforehand should envisage the exhibition

as the beginning or climax of continuing activity, and one or two themes should be selected in advance for continuity.

It should not be necessary to spend large sums of money on exhibitions if full use is made of all the free material and voluntary services which traders and the public are willing to give.

Small mobile exhibitions are effective if used at key-points of interest, such as the health centre, a cinema foyer or shop window, or the waiting-rooms of hospitals. In some cases, the exhibit, suitably secured, may be out of doors at a bus stop or railway station. Such exhibits, like posters, need to be changed frequently.

In some cases health museums have undertaken the organization of these extramural activities, but they should not be beyond the resources of any health administration, however small, if local talent is enlisted.

Examples of Community Participation

Rural area [1]

Beginning with the demand of the people for treatment of their skin diseases, a cleanliness campaign was carried out by the villagers, and then a welfare centre established. A villager was then trained for visiting the homes and looking after the welfare of the children. Later, gardens were started, to produce vegetables needed to enrich the diet. A desire for soap led to the setting up of a co-operative store, and trainees were taught to weigh goods, to serve, and to count, the village leaders themselves running the shop. A fire in the village caused great co-operative effort and led to plans for building new homes, a co-operative cattle shed, a craft-work centre, and a village crèche.

Semi-rural area [2]

In this area concern about the health of the rural 90% of the population gave rise to the formation of a health demonstration and training centre. The area had an estimated population of 35,000 and four existing health centres, through which the demonstration programme could work.

After a preliminary survey of two typical districts to learn the main health problems, the first step was to enlist the support of the " barrio " lieutenants [3] and local leaders, and to organize a community meeting at

[1] See: McLaren, I. M. (1946) *African world*, August issue.

[2] See: Tiglao, T. V. (1952) *Fundamental education: a quarterly bulletin*, **4**, 40 (UNESCO).

[3] These were men appointed by the Mayor to take charge of neighbourhoods on a voluntary basis.

which the Mayor, the City Health Officer, Councillors, the Schools Superintendent, and the Social Welfare Administrator explained the government's programme to the people and also heard their views. As the people's interest grew, citizens' health and welfare committees were formed in each district. These committees have been active in organizing the construction and repair of drilled wells, the repair of roads, and the putting up of road signs. They also spread information to the people regarding health services available, which has resulted in a greater attendance at ante-natal and well-baby clinics, an increased willingness to enter hospital, and an increasing demand from the women for the services of nurses, licensed midwives, or doctors during delivery. One committee has built a health centre with the help of donations of money and materials from civic and university sources and labour from the community. At the same time in-service training meetings of health workers, physicians, nurses, midwives, and sanitarians have been held. Conferences organized for leading school personnel were followed by in-service training for teachers, and health education material has been made available to help in the work of health education in schools. Newly-formed parent-teacher associations have also helped to bring about changes; for example, the supervision of the school luncheon has been taken over by the school instead of the food vendor at the school gate. Study-groups, where a variety of subjects are discussed, have been formed and are well backed up by materials, pamphlets, posters, films, etc., produced by the Rural Health Demonstration Centre. (This report was written after the health-education programme of the Rural Health Demonstration Centre had been in operation for two years.)

Urban area

An example of widespread participation in a short-term programme is provided by a recent campaign on foot health. This campaign was organized in Birmingham, England, in October 1953, by the Foot Health Educational Bureau of the Central Council for Health Education in co-operation with the Birmingham City Council. After preliminary consultations and division of responsibility between the health educationists and the local health authority, the following events took place during five days. The Mayor and the Chairman of the Health Committee opened an exhibition and a series of meetings. The exhibition was the product of several manufacturers and professional organizations. This involved co-operation by the manufacturing and retailing industries and the professional organizations in considering the principles of foot health from each other's point of view. This was amplified by arranging a series of small meetings separately and together for shoe-fitters, public-health nurses,

doctors, physiotherapists, chiropodists, and manufacturers, where all aspects of the problem of foot deformity were discussed in turn. The exhibition was visited by school parties and the public. An inaugural meeting for the general public was widely reported in the press and introduced well-known celebrities who depended on their feet for their livelihood.

By this means nearly all sections of the public took some direct part in the proceedings and changed their attitude as a result. The follow-up will carry the interest into the clinics and schools through the teachers, children, and parents who took part. The liaison between trade and medical profession will be maintained by regular conferences.

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