

# STATUS OF HEALTH EDUCATION SERVICES IN INDIA

## REPORT OF THE NATIONAL CONFERENCE

**(FEBRUARY 26-29, 1980)**

**Under W.H.O. Project No. IND-HED 005**

*Organized by :*

**CENTRAL HEALTH EDUCATION BUREAU  
DIRECTORATE GENERAL OF HEALTH SERVICES  
KOTLA ROAD  
NEW DELHI - INDIA**

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## PREFACE

The Central Health Education Bureau (CHEB) was established in 1956 with a view to develop health education on scientific lines in the country. In 1959, the CHEB prepared a scheme for the establishment of State Health Education Bureaux in the State Health Directorates. Financial assistance was offered to the States by way of 50 per cent recurring and 100 per cent non-recurring grants during the Second Plan period but this assistance was discontinued after the Fourth Plan. Consequently, there has not been a uniform development of health education activities in the country. While, some States have done extremely well in establishing Health Education Bureaux, a number of them have set up a nucleus.

The Central Health Education Bureau took up a study in 1979 to review the status of health education services in the country. The study, among other things, covered assessing the present position of health education in India, especially in the light of its important place in the new health policy of the government, analysing the reasons for lop-sided growth of the programme in States and Union Territories, and considering the possibility of having a cadre of health educators. It also covered a review of health education content in the syllabi of various categories of health personnel such as medical, nursing and para-medical personnel, teachers, trade union leaders, etc., and make suitable recommendation and indicate research needs in health education.

This study covered all States and Union Territories as well as training and service institutions working in both health and non-health fields. Nearly 1700 organisations were covered for the study.

Based on the response to the questionnaires, personal interviews, a Report on Status of Health Education in India was compiled. This formed the background material for a National Conference on Status of Health Education Services in India held in New Delhi from 26 to 29 February, 1980. The Conference was attended by 62 participants. They were either senior health administrators, Professors of Preventive and Social Medicine of Medical Colleges and Health Educators from all over the country. The Conference made recommendations for promoting and strengthening health education in the following areas: Health Education Specialists; Health Professionals; Community Health Education—Central and State Health Education Bureaux, and School Health Education.

The Conference provided an excellent opportunity to share varied experiences in planning and implementing health education programmes at various levels. It also highlighted the wide differences in the set-up of State Bureaux and health education units at other levels like medical colleges, nursing institutions, municipal bodies and public sector undertakings.

The Conference also provided another opportunity to reveal the vital role that media in general, and mass media, in particular, could play in promoting health consciousness and knowledge among the people.

The following pages of this report provide a detailed resume of the activities undertaken by the Bureau in planning, conducting and evaluating the four-day Conference. The recommendations are given separately and as part of the four group reports.

The report would prove useful to all health administrators with a deep commitment to health education and striving to give it the due place in various health programmes. I am also sure the recommendations made at the Conference would be sincerely followed up and the discipline promoted at various levels.

21-1-1981

(Dr. B.C GHOSAL)  
DIRECTOR, CHEB

## ACKNOWLEDGEMENTS

We are extremely thankful to Shri Nihar Ranjan Laskar, Minister of State for Health and Family Welfare for inaugurating the National Conference on Status of Health Education Services in India organized by the Central Health Education Bureau from 26 to 29 February, 1980 in New Delhi.

We deeply acknowledge the inspiration and support provided by Shri Kripa Narain, Secretary, Ministry of Health and Family Welfare and Shri P. Sabhanayagam, Secretary, Ministry of Education and Culture. We are grateful to Dr. B. Sankaran, Director General of Health Services, Dr. I.D. Bajaj, Addl. D.G. and Dr. Ranjit Sen, DDG(P), for their constant guidance and support.

We gratefully extend our thanks to members of the Planning Group of the Conference. Their constant direction and cooperation was not only a great source of inspiration, it also helped in generating a most congenial atmosphere for the deliberations.

We are specially thankful to the World Health Organization for providing financial assistance for undertaking this big project, *viz.*, to assess the status of health education services in the country and to plan and organize the Conference.

We deeply acknowledge the cooperation and assistance provided by the various voluntary and Government agencies, especially the States/Union Territories in collecting the necessary information.

We are grateful to the staff of the CHEB for their active cooperation and assistance in the organization of the Conference specially to the Research Division, the Exhibition, Art, Audio-visual and Editorial Units of Media Division and the Administration and Secretarial Divisions.

We gratefully acknowledge the contribution of Dr. A.B.Hiramani, Dy. Director (Research) and the staff of the Research and Evaluation Division of CHEB in preparation of the status study report. We also acknowledge the contributions of Shri T.K. Parthasarathy, Shri D. Lakshminarayan and Shri P.N. Khosla in the preparation, editing and production of the report.

Dr. B.C. Ghosal

Dr. S.A. Pandit

Smt. C.K. Mann

*Conference Director*

*Conference Co-Director*

*Conference Co-ordinator*

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# INTRODUCTION

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The significance and important role of health education for promoting health status of people—be it a community, a group, or an individual, has been recognised in our country since ancient times. Priests, folk practitioners and rulers have all influenced the health consciousness of their time.

The importance of this discipline has grown in the past decades, as progress of behavioural and social sciences has helped in gaining new knowledge on human behaviour. Experiences in implementing health programmes have also revealed that people's participation is vital for sustained progress of all health programmes. In the context of India's objective to provide health for all by 2000 A.D., health education assumes a pivotal role. This is because health education makes an individual health conscious, provides him with knowledge on health matters, and promotes in him the requisite desire and motivation to avail of health services and stay healthy.

## Genesis

The Central Health Education Bureau (CHEB) was set up in 1956 with a view to develop health education on scientific lines in the country. Prior to this development, a Health & Publicity Division in the Directorate General of Health Services was responsible for health education activities. The Division was engaged in bringing out educational and publicity materials on different health subjects on an ad hoc basis and providing audio-visual facilities such as organizing film shows in and around Delhi.

To develop the health education programme all over the country, the CHEB prepared a scheme for the establishment of State Health Education Bureaux (SHEBs) under the State Health Directorates. For this purpose financial assistance was offered to the States by way of 50 per cent recurring and 100 per cent non-recurring grants during the Third Plan period. Health being a State subject, this assistance was discontinued after the Fourth Plan. Consequently, uniform development of the SHEBs did not take place. Further, in the absence of a strong coordination between the CHEB and SHEBs, a few State Bureaux became defunct and others required strengthening and revitalizing in order to perform well and yield returns.

A decision was taken in 1978 to carry out an assessment of the current status of health education in the country and to identify the areas for its strengthening and development,

Next year, an in-depth study was undertaken by the CHEB to ascertain reasons for the lop-sided development of health education in the various fields and disciplines. The study, among other things, covered assessment of present position of health education in India, especially in the light of its important place in the new health policy of the Government and also to consider the possibility of having a cadre of health educators. It also included a review of health education content in the syllabi of formal and non-formal education/training of various categories of health personnel such as the medical, nursing, para-medical, teachers, etc.

### **The Study**

The mechanism evolved to seek the requisite information was (1) study tours to different States by senior faculty members of the Bureau, (2) preparation and mailing of a set of questionnaires to various voluntary and governmental institutions engaged in health and non-health fields and covering all the States and Union Territories.

Nearly 1700 organizations were covered by the study and the information sought from them related to the following :

- (i) To assess the present status of health education in the country, especially in the light of its important place in the new health policy of Government.
- (ii) To find out the reasons for lop-sided growth of health education in the States and Union Territories.
- (iii) To assess the extent to which health information is being disseminated through the different media channels of the governmental agencies, both at the Centre and States.
- (iv) To consider current status of health education in the country and work out the possibility of having a cadre of health educators.
- (v) To review the contents of health education in the syllabi of the various categories of health personnel such as medical, nursing, para-medical, teachers, etc., and to make suitable recommendations for further strengthening.
- (vi) To identify and indicate research needs in health education.
- (vii) To assess the extent of integration of health education in the formal and non-formal systems of education at various levels (formal education—primary, secondary, university and teacher training levels and non-formal—rural and urban).

Nearly 2700 copies of the questionnaires were sent to various institutions. Of these, 720 or approximately 27.09 per cent were received back with relevant data. Response from State Health Education Bureaux was the highest, being 72 per cent, while feedback was least from the district health education units. It was only 15 per cent

The Summary Report of the findings of the study is placed at *Appendix 1* of this report.

## **Planning for the Conference**

A Planning Group for the National Conference was constituted under the Chairmanship of Dr. B.C. Ghosal, Director, CHEB. Dr. (Kum.) S.A. Pandit, D.A.D.G. (HE), CHEB, was designated as Co-Chairman, and Smt. C.K. Mann, H.E.O. (T) as Coordinator. The other members were all Deputy Directors and senior D.A.D.Gs. The Planning Group held a series of meetings to decide the strategy for effective planning and organization of the Conference. (Members of Planning Group are listed in *Appendix IV*).

Senior faculty members of the CHEB, including the Director, visited some of the States and Union Territories and held discussions with the State health administrators to review the present status of health education in the States. The Planning Group then reviewed the report of the Status Study and in the light of its findings formulated the objectives of the Conference. It also worked out the major areas for the Conference deliberations, *i.e.*, (1) specialists' training, (ii) professionals training, (3) community health education, and (4) school health education.

A Sub-Committee consisting of some of the members of Planning Group was then constituted to work out uniform guidelines for the Conference proceedings on each of the four areas listed above. This exercise was undertaken with a view to provide some sort of uniformity for Conference deliberations so that the set objectives were achieved within the available time. (See *Appendix VI* for guidelines).

The participants to the Conference were carefully drawn from all over the country. Being a national level Conference to deliberate on the status of health education in the country, selection of the participants was made in a manner so as to ensure participation from all States and Union Territories of the country. Secondly, keeping in view that a strategy for strengthening health education was being developed, participation was ensured of (i) senior health administrators responsible for policy planning and implementation, (ii) Professors of preventive and social medicine department, (iii) health educators responsible for actual implementation and augmentation of programme, and (iv) representatives of voluntary organizations for wider acceptance and application to make health education really a people's programme.

There were sixty-two participants in the Conference. A list of those who participated is given at *Appendix III* of the Report.

## **The Programme**

The detailed programme schedule of the Conference was worked out keeping in view the objectives to be accomplished, the time available and the background



of the participants. Care was taken to allot sufficient time for group work so that participants could get sufficient time to contribute maximum to the proceedings. The plenary sessions were related to all the major areas of the deliberations. Selection of speakers at the plenary sessions was made with utmost care in order to have persons with rich and varied experiences in their fields who could generate new thinking among the participants. (See *Appendix V* for Conference Programme).

A number of relevant background papers were selected from a comprehensive list prepared for it, keeping in view the objectives. Some background papers were also supplied by the speakers of plenary sessions and other participants. (List of papers from speakers and of CHEB are given in *Appendices VII* and *VIII* respectively.)

### **General Objectives**

The General objectives of the Conference were as follows :

1. To review current status of health education in the country on the basis of information received from various States with respect to training, research, media and health education services.
2. To propose a strategy for strengthening health education services in the country.

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# SUMMARY OF PROCEEDINGS

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The Central Health Education Bureau (CHEB) organized a National Conference on Status of Health Education Services in India in New Delhi from 26 to 29 February, 1980. The four-day Conference was organized to study the current status of health education in India at various levels on the basis of information gathered from different States and Union Territories and then to propose a strategy for strengthening the programme.

Prior to conducting the Conference, the CHEB carried out an in-depth study in 1979 to examine the status of health education programmes being organized at different levels in the country. The World Health Organization provided financial assistance for conducting the study as well as for organizing the Conference.

The study report was placed in the Conference for review and formed the basis for discussions and framing recommendations.

The Conference was attended by representatives from sixteen States and Union Territories. It was also attended by representatives from Planning Commission, University Grants Commission, Ministry of Information and Broadcasting, Education Ministry, Senior Officers from Ministry of Health & Family Welfare, and the Directorate General of Health Services, the World Health Organization and voluntary organizations.

## INAUGURAL SESSION

The Conference was inaugurated by Shri N.R. Laskar, Union Minister of State for Health and Family Welfare. In his inaugural address, Shri Laskar said that the message of health "should get woven into the fabric of our society and our daily life styles in the homes". This, the Minister felt, could be achieved "not only by inculcating knowledge and attitudes in the leadership in the community at all levels, but more importantly in the growing generation of our country".

Shri Laskar called upon the Conference participants to develop proper approaches for health education work. Though health was a State subject, the Centre would do its best to persuade the States to give a high place to health in their order of priorities. "Whatever we can do from the Centre, we shall do it", he added.

## **Secretary's Address**

Shri Kripa Narain, Secretary, Ministry of Health and Family Welfare, who chaired the inaugural session, was of the view that the tasks of health educators were very challenging. He felt that people could at best be only helped in what they would like to achieve in matters related to health. They had a major part to play in keeping themselves healthy.

Shri Kripa Narain stressed the importance of preparing the community health volunteers (CHV) for their educational roles. In this context he also said that the CHVs selected should be respectable and honoured persons of the community and not youngsters "looking for jobs". He advised the Conference participants to suggest such measures that the CHVs and other village functionaries such as Gaon Sabha representatives, teachers, etc., received suitable educational aids for doing health education work.

Shri Kripa Narain said that the concept of 'Health for All' by 2000 A.D. was "easy to say, difficult to comprehend and more difficult to execute". Health was complete well being and no system of medicine, whether allopathic, homoeopathic or indigenous could alone provide this. Secondly, it was essential that the person for whom we were working knew about his health needs. This could be achieved through health education.

The Secretary said that health education messages including those on family planning, need not always be given directly. They could be rather interspersed during discussions on other subjects like fertilizers, agricultural insecticides, etc. "A casual remark, well meant, often goes deep", he added.

Shri Kripa Narain concluded his address with three points for the guidance of the participants. (1) The community is more important and government machinery is to help the community. (2) Try to prepare guidelines, visual aids, manuals for the community health volunteers, and (3) approach the other sectors like agriculture also so that their workers when they go to the field in the rural areas, could casually and pleasantly talk about the small family norm and health to the people. This would be more effective in creating awareness among people.

## **DG's Remarks**

Earlier, in his address of welcome, Dr. B. Sankaran, Director General of Health Services, described the Conference as "a very significant and important step in our endeavour to promote health services".

Dr. Sankaran said that India's greatest asset was her manpower and health education of the people on health matters was a must. Progress in health should not be wrongly measured in terms of number of hospitals, beds, doctors, etc., but equated with what is being made available in the health care services to the villagers. All health workers including teachers, CHVs., etc., should be educators, the Director General added.

## **WHO Representative's Views**

Dr. D.A.W. Nugent, WHO Programme Coordinator in India, in his brief address, said that everybody spoke of the importance of health education, but was in the habit of "thrusting it on others". He asked whether enough budget was being provided for the discipline. Though being a job of everyone, health education needed specialization and in this context he expressed happiness that India was taking the right steps in preparing professional health educators.

## **Scope & Objectives of the Conference**

Dr. B.C. Ghosal, Director, Central Health Education Bureau, explained the scope and objectives of the Conference. He hoped that the participants would be able to visualize such plans and programmes for the development of a health education strategy that would be acceptable both to the administrators and planners. He gave details of the steps taken by the Bureau in conducting the Study on the status of health education and thanked the World Health Organization for providing support both for the study and the Conference.

Dr. I.D. Bajaj, Additional Director General of Health Services, proposed a vote of thanks. He thanked the Minister for providing guidance at the right time and hoped that the participants would keep in mind the useful suggestions made by the Secretary in his address. He particularly thanked the World Health Organization for its support.

Dr. Bajaj had a special word of thanks for the staff of the Central Health Education Bureau for their hard work for conducting the Conference.

After the Coffee-break, the participants re-assembled for a short session at which the various groups of the Conference members were formed. Dr. Ghosal chaired the session. Four groups formed were assigned work on: (1) Health Education Specialists, (2) Health Professionals, (3) Community Health Education, and (4) School Health Education. Dr. Ghosal also announced the formation of three Committees of the Conference, viz., (1) Editorial Committee, (2) Evaluation Committee, and (3) Steering Committee.

## **PLENARY SESSION I**

### *SUMMARY REPORT PRESENTATION*

The afternoon session of the day was devoted to a presentation on the highlights of the Summary Report of the Study on 'Status of Health Education Services in India' by Dr. B.C. Ghosal. Shri N.N. Vohra, Joint Secretary, Ministry of Health, chaired the session.

The Report revealed that health education services in the country had developed in a lop-sided manner and needed strengthening at every level, viz., State, District, PHC and institutional levels like medical colleges, nursing institutes, ANM Schools, and in the programmes for MPW/CHVs.

The Status of health educators needed improvement. There was also need for uniformity in their pay-scales. Research in health education needed strengthening.

Shri N.N. Vohra, in his remarks, said that in view of the constraints of resources, our emphasis should be on reducing the number of people visiting hospitals and on preventive and promotive aspects of health. Health education had to play an important role in this regard. However, keeping in view the vast variations in the country's socio-economic conditions, cultural background, the educational approach should be suitably oriented to meet specific needs. He also wanted medical colleges and private medical practitioners to be more intensively involved in health education programme.

The session ended with a vote of thanks proposed to the Chairman by Dr. Ghosal. Later, a detailed discussion was held on the report. Dr. Ghosal informed the participants that all the suggestions would be kept in view during the group work and while drafting the recommendations.

## PLENARY SESSION II

### *TRAINING IN HEALTH EDUCATION*

The second day's deliberations of the Conference were devoted to a presentation on training programmes in health education for different categories of workers.

Dr. I.D. Bajaj, Additional Director General of Health Services, chaired the session. In his introductory remarks, Dr. Bajaj said that the subject was extremely useful in the present context of health programmes.

#### **Health Education in Medical Curriculum**

Dr. Harcharan Singh, Professor and Head of SPM Department, Medical College, Patiala, was the first speaker. He described the status of health education component in the medical education curriculum and gave a detailed background of the various councils and bodies which had recommended integration of health education in medical education curriculum. He expressed regret that not much had, however, been achieved in practice. He also gave details of the areas of health problems where health education could be interwoven to get better results from health programmes.

Dr. Harcharan Singh read out statistics based on a study in relation to some diseases in one of the large hospitals in the country which showed the level of ignorance among people about disease process, dosage of medicine to be taken, etc. It was very clear, he said, that the medical curriculum needed change and students made to constantly observe health education being practised as an integral part of all medical services.

Dr. Harcharan Singh concluded with the observation that all health workers should be made to realize the "magical strength" of education in changing the behaviour of people.

#### **Diploma in Health Education**

Dr. Lois Philip, Professor of Health Education at the All-India Institute of Hygiene & Public Health, Calcutta, who spoke next, reviewed the existing position of the Diploma in Health Education Courses being conducted in the country and scope for modifications in them.

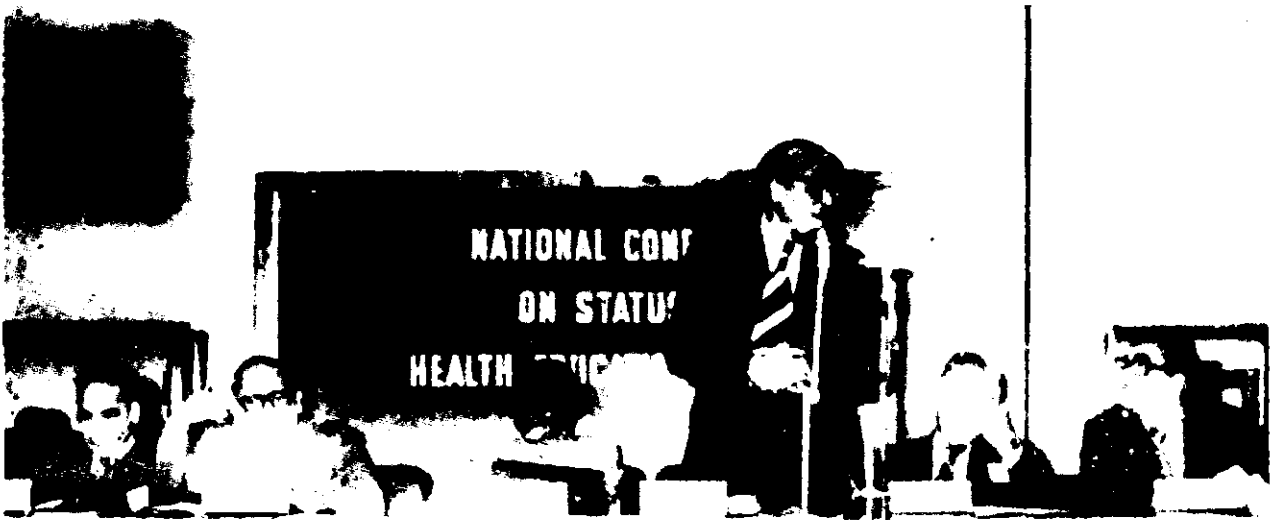


Shri N.R. Laskar, Union Minister for Health & Family Welfare, arriving at Vithalbhai Patel House to inaugurate the National Conference on Status of Health Education Services in India on 26 February, 1980. Shri Kripa Narain, Secretary, Ministry of Health and Family Welfare and Dr. B. Sankaran, Director General of Health Services, receiving Shri Laskar.

Shri Laskar delivering the inaugural address at the Conference.

A view of the participants. ↓





Shri Kripa Narain delivering his address at the inaugural session



Dr. Sankaran welcoming the participants to the Conference.





Dr I.D. Bajaj, Additional Director General of Health Services, speaking at the Conference.

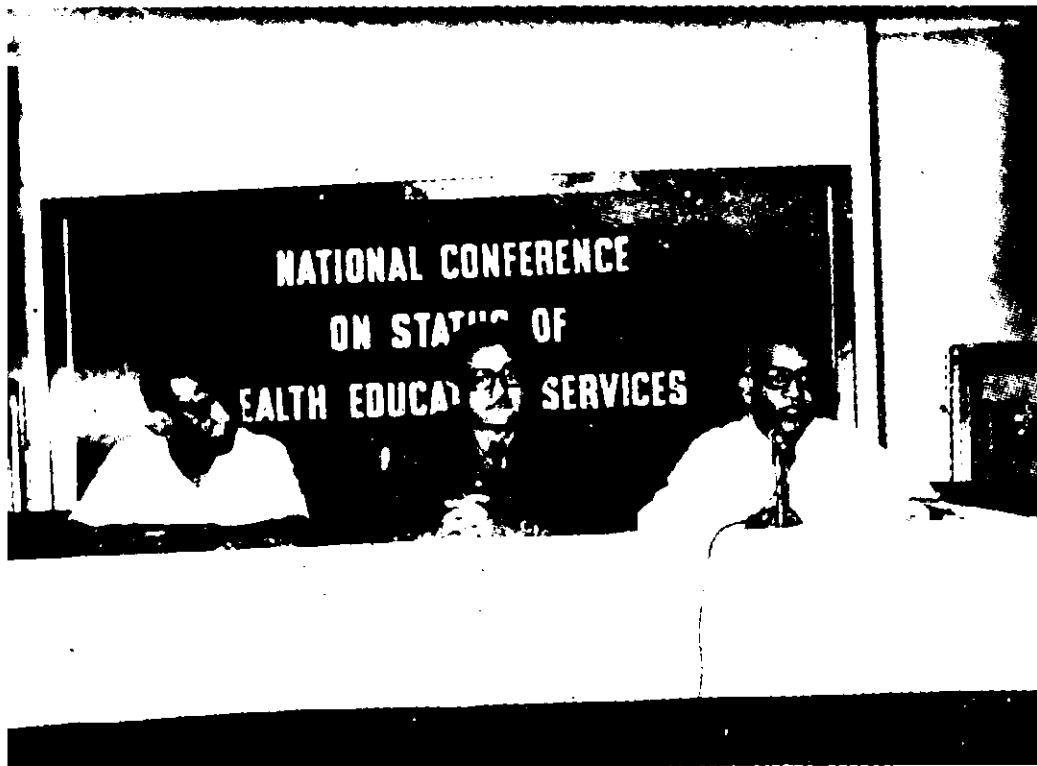
Dr. D.A.W. Nugent, WHO Programme Coordinator in India, addressing the participants on the inaugural day.



Dr. B C. Ghosal, Director, Central Health Education Bureau, explaining the scope and objectives of the Conference.



Shri N.N. Vohra, Joint Secretary, Ministry of Health & Family Welfare, offering his remarks on the report of the status study presented at the Conference.



Dr. S. Abdul Kareem, Joint Director (HE & SH), Karnataka, addressing the Conference.

Dr. A. B. Hiramani, Deputy Director (Research), Central Health Education Bureau, speaking on behavioural research related to health education. Earlier, Dr. (Kum) S A. Pandit, D A.D.G. (H.E.), CHEB spoke on the origin and development of State Health Education Bureaux.



Dr. Philip observed that many health educators appointed were not properly equipped and trained to do justice to their jobs. When laboratory technicians needed some basic minimum qualification and training for working on these posts, health educators holding gazetted posts should surely be equipped to perform their jobs well. She felt that DHE could be made an essential qualification for recruitment as health education specialists. She felt that some medical colleges could also take up organization of DHE courses.

Dr. Philip pleaded with the Addl. D.G. to increase the amount of stipend for DHE trainees as was being done by States like Karnataka, Orissa and Gujarat. She said that the Centre should allow its employees to attend DHE course with full pay and stipend as was being given to State Government employees.

### **Nurses & Health Education**

The third speaker was Dr. (Smt.) S. Krishnan, Principal, R.A.K. College of Nursing, New Delhi. She said that all health functionaries, be it a doctor, a nurse or a para-medical person, needed skills in communication as one of the essential requirements. She said that she was sorry to record that although big resolutions were passed in seminars, conferences, etc., nothing concrete was being achieved. This she attributed entirely to what she called as human failure. This was a major hurdle to be overcome by all members of the medical team if health education was to make a real dent. She gave details of some of the elements of health education components being taught to nursing personnel through various training courses. She also emphasized that all health workers should be familiar with the culture in which they were to serve the community if they meant to do real justice to their jobs.

### **Health Education for Students**

Speaking next, Dr. B.B. Ganguly, Professor, National Council of Educational Research and Training (NCERT) gave details of the attempts being made by the Council to introduce health education in its 26 departments through both formal and non-formal systems of education. Although the present efforts were good, there was scope for doing much more in the field. Dr. Ganguly was critical of 'one-sided approach' in the teaching of all subjects as separate entities. This had resulted in the overloading of curriculum of the students. Indeed, every child had become a 'moving encyclopaedia' and was being overloaded with knowledge but without the scope to explore further.

Dr. Ganguly pleaded for a new approach in making health education a part of the entire learning process. Pilot projects could be undertaken in this area and the NCERT would be happy to collaborate with CHEB in any such endeavour.

### **Inservice Training in Health Education**

Dr. N.N. Biswas, Dy. Director (Training) CHEB, speaking next, gave useful information on the experiences gained by CHEB in the area of inservice training programmes for various categories of health personnel. He said that in the context of 'Health for All' by 2000 A.D., sincere efforts were needed to train workers in

health education and implementation of the skills learnt in the job situation. The training programmes could be modified from time to time to suit the needs.

### **Health Education through Adult Education**

The last speaker of the session, Dr. A.K. Jallaluddin, Director, Directorate of Adult Education, speaking on health education programmes in adult education, said that with coordinated work, resources and facilities of both programmes could be utilized to the maximum benefit. This would also avoid overlapping or contradictions in teaching health education component. He further said that our villages were tradition-ridden, some were good and some obsolete. The community had its own way of thinking and government functionaries should not thrust their thinking on it. He reiterated that total mobilization of the nation was required to achieve results.

It was difficult to change the villagers overnight, Dr. Jallaluddin said and added that instead of sending peripheral workers to the villages to educate the people, a number of young persons who were educated and unemployed, could with some preparation, educate the villagers in their own way. They could be given incentives.

Dr. Jallaluddin said that during the two-year period that the adult education programme had been in operation, the department had learnt a lot from the health education programme operators and the programmes modified suitably.

## **PLENARY SESSION III**

### *BEHAVIOURAL RESEARCH IN HEALTH*

The afternoon session of the second day's deliberations was devoted to 'Review of Behavioural Research in Health and Family Welfare and the Future Strategy'.

Dr. Ashish Bose, Director, Institute of Economic Growth, New Delhi, chaired the session.

### **Family Welfare Research**

The first speaker, Dr. N.R. Parthasarathy, Jt. Director, Backward Classes Commission, presented a paper on "Review of Family Welfare Planning Research in India". The paper traced the history of family planning in India and development of the programme over the years in the country.

Dr. Parthasarathy suggested improvements which, he felt, could bring better returns from the research work done so far. He agreed that government was keen to step up family planning research so that these could help to push up the programme further.

### **Behavioural Research**

Dr. A.B. Hiramani, Dy. Director (Research), CHEB, in his paper on "Review of Behavioural Research in Health Education in India", traced the history of the research work on the subject in the country and then gave a detailed account of the

activities undertaken by the CHEB from 1960 onwards. He also stressed the need for increased collaboration with and participation of universities and research institutions in this sphere and made a strong plea for adequate funds. This would help in sponsoring studies by various universities and research institutions.

Dr. Hiramani enumerated five basic problems which, he felt, were mainly responsible for the inadequate development of health education research in the country. These were : insufficient research in health education, problem in the design and conduct of research, preparation of trained health professionals, problems of communication and the lack of funds.

### **Dr. Bose's Views**

Following Dr. Hiramani's presentation, Dr. Ashish Bose made a few observations about the health and family welfare programmes. The first point Dr. Bose made was that unless rural sanitation and environmental conditions improved, the health indices of the country could not become better. The Planning Commission and the Health Ministry, he said, should give some importance and funds for these areas as for buildings and drugs. In fact, environmental sanitation in rural areas should be an essential item under the minimum needs programme and in this context, "health education is a pre-requisite in rural health services".

Secondly, he said that while family planning awareness had been created in the rural areas and people now identified red triangle with family planning, little improvement had been noticed in the provision of health care services in rural areas. This would have an adverse effect on family planning motivation. He said that if infant and maternal mortality rates were reduced and health status of the people improved, these themselves would pave way of adoption of the small family norm.

About the Community Health Volunteers Scheme, Dr. Bose was of the opinion that the Health Ministry should call a high level meeting to do a thorough study on the progress of the scheme. Great expectations had been aroused by the CHV Scheme and therefore the volunteers who were now in the periphery should be properly equipped with kits and drugs.

## **PLENARY SESSION IV**

### *MEDIA IN HEALTH EDUCATION*

The morning session of the third day of the Conference saw media men sharing experiences on utilization of various media for the health and family planning programmes.

Shri K.S. Srinivasan, Director, Press Commission of India, chaired the session. In his remarks, Shri Srinivasan emphasized the importance of close inter-dependence of all communication media in our country in order to carry information and knowledge to the people. In this context, the role of conventional media in dissemination of information should not be overlooked.

### **Health over AIR**

Shri V.K. Mathur, DDG, All India Radio, New Delhi, the first speaker, gave a resume on the use of the radio for disseminating health and family welfare

information. All types of formats were being utilized for this purpose and analysis of programmes had shown that health programmes were very popular among listeners for promoting their health knowledge. He said that though the radio media had done extensively good work for creating awareness about health and family planning, this had to be cashed upon by the extension approach for bringing about behavioural change.

### **TV and Health**

The next speaker, Kum. Sipra Ray, Dy. Director (Programmes) Delhi Doordarshan, presented details about the work being done by the Doordarshan Kendras all over the country, including the Upgrah Continuity Centres (SITE) for promoting the health and family welfare programmes. She said that the TV programmes laid emphasis on preventive and promotive aspects of health

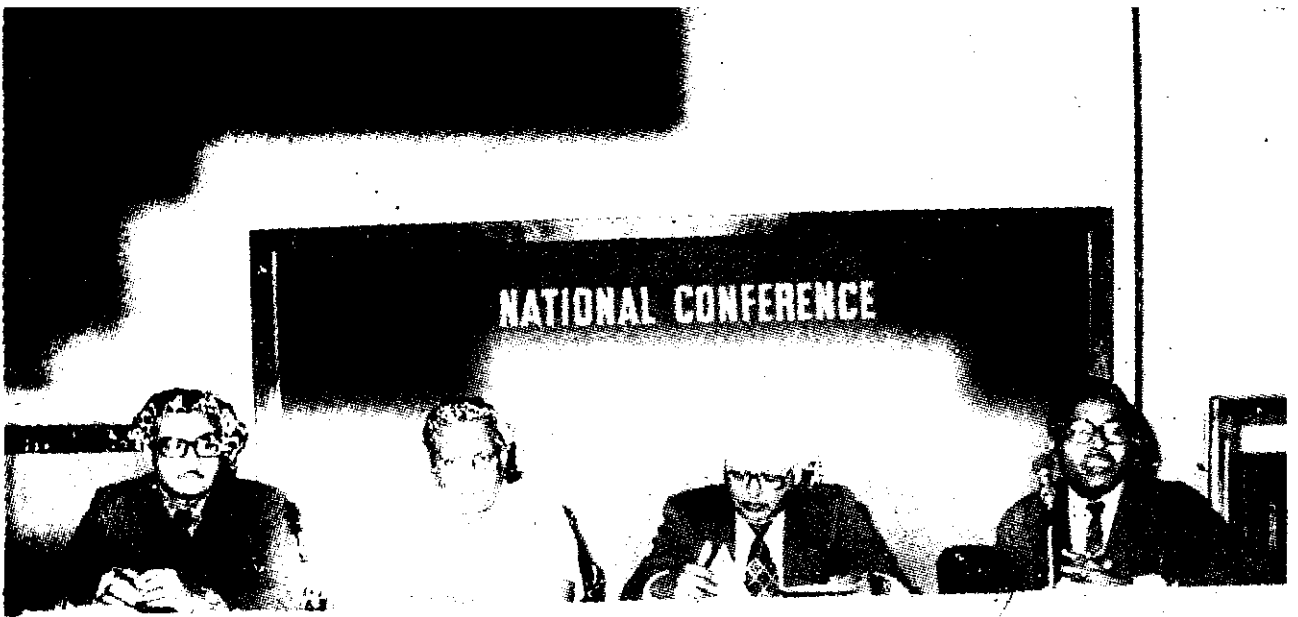
Kum. Ray said she did not consider television as a luxury medium for India as was being usually said. Its potential to convey health messages was tremendous and this had been amply demonstrated during the SITE project. The SITE Continuity Project was being continued through seven terrestrial transmission centres in the country. She said that television was faced with lack of infrastructure and non-availability of resources.

### **Media Support in SHEBs**

Shri T.K. Parthasarathy, Editor (CHEB), reviewed the position of media availability and support being provided by the State Health Education Bureaux in health education programmes. Despite constraints of resources, the States were doing good work in the production of printed materials for health education, organizing training for workers, etc. Many PHCs depended on SHEBs for their material support and even the family planning material were being produced at the State level although infrastructure existed at the district family planning units. He called upon the participants to consider measures for improving the support that the States should receive in order to better their performance in this sphere.

Shri Parthasarathy said that the status study report had revealed that most of the States were utilizing radio and television, where available, for giving health information. In this context he recalled the impact radio could create on the listeners. A script on smoking developed by CHEB had such an impact on some people that they gave up smoking. He also recalled the big role played by Radio and Doordarshan in transmitting information and knowledge to people about solar eclipse. These two media could help in the promotion of knowledge on health and family welfare.

Shri K Balasubramanyam, Technical Officer (CHEB), spoke on the efforts being made by the Central Health Education Bureau in utilizing the film and other audio-visual media to promote health. He gave details of the films produced by the Bureau in collaboration with Films Division of the Information and Broadcasting Ministry during the last three years. He wanted the States to intimate their bulk demand so that the required number of prints could be prepared. He also gave details of the slides, radio spots and other campaign materials produced by the Bureau through the Directorate of Advertising and Visual Publicity.



Dr. B.B. Ganguly, Professor, National Council for Educational Research & Training, speaking on health education for students.

Dr. A.K. Jalaluddin, Director, Directorate of Adult Education, speaking on promoting health education through adult education programme.

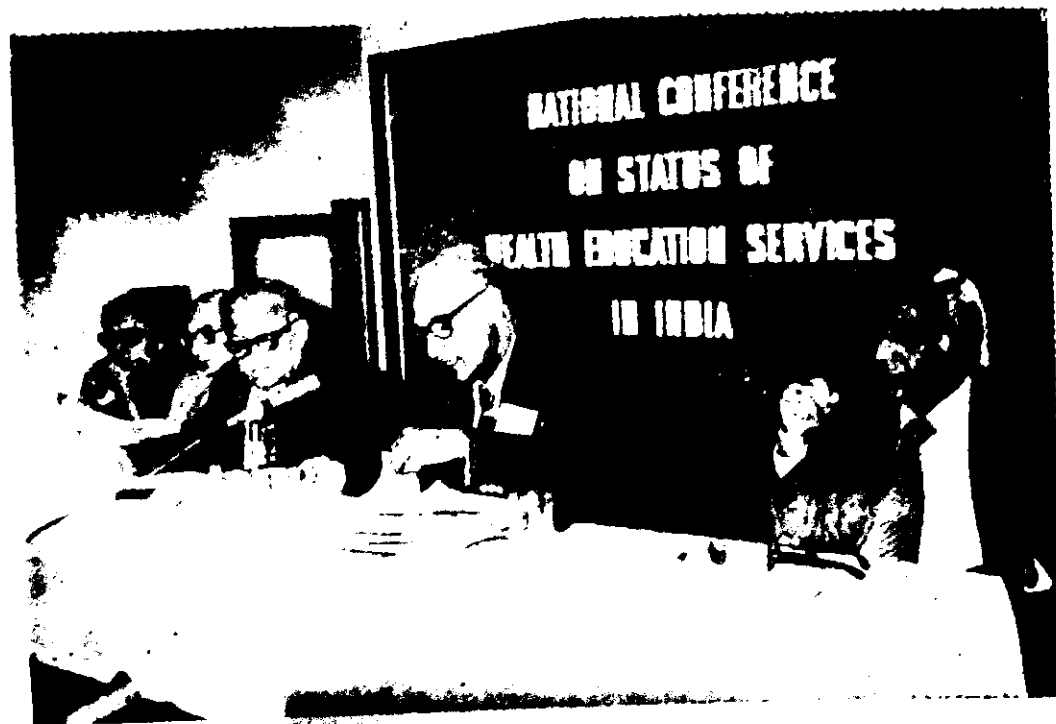


Shri K.S. Srinivasan, Director, Press Commission, speaking on media in health education.

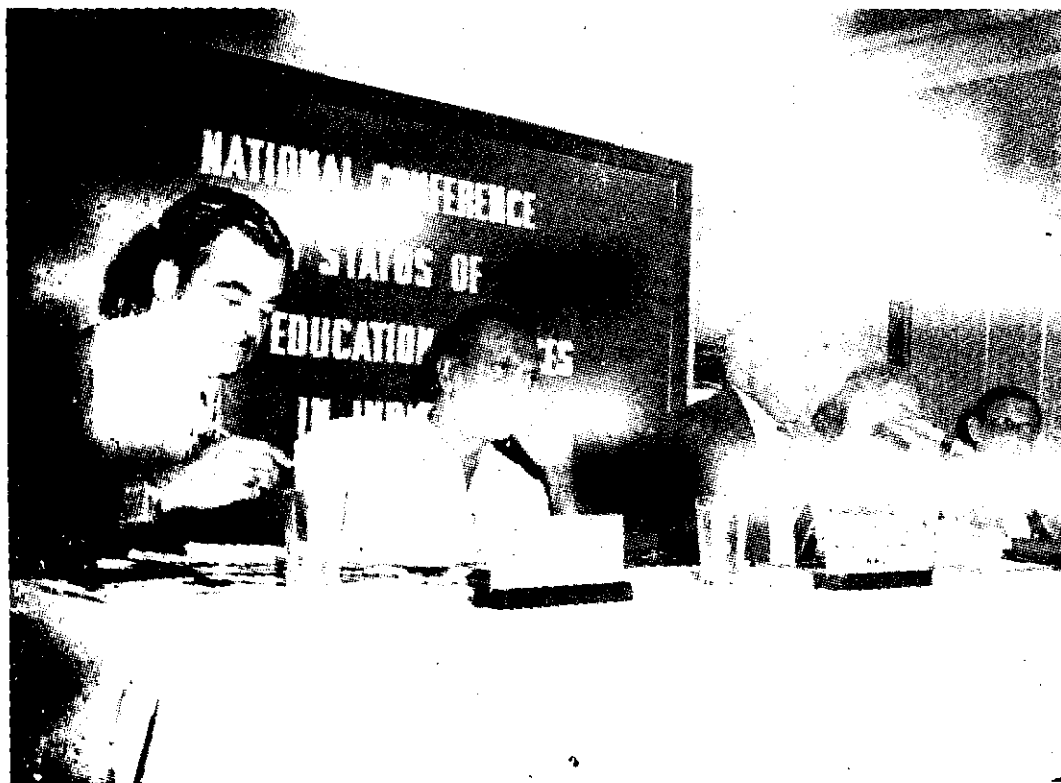
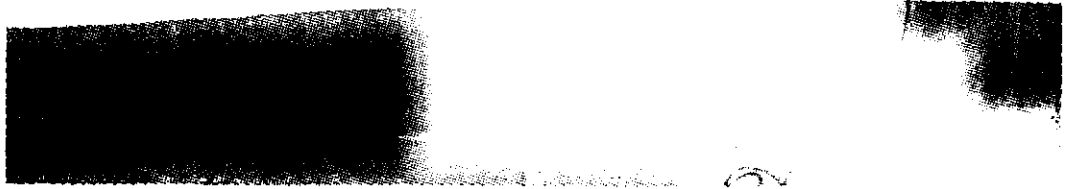


Shri V.K. Mathur, Deputy Director General, All India Radio, speaking on the promotion of health through the network of AIR stations.

Shri T.K. Parthasarathy, Editor, Central Health Education Bureau, reviewing the media availability in the State Health Education Bureaux.

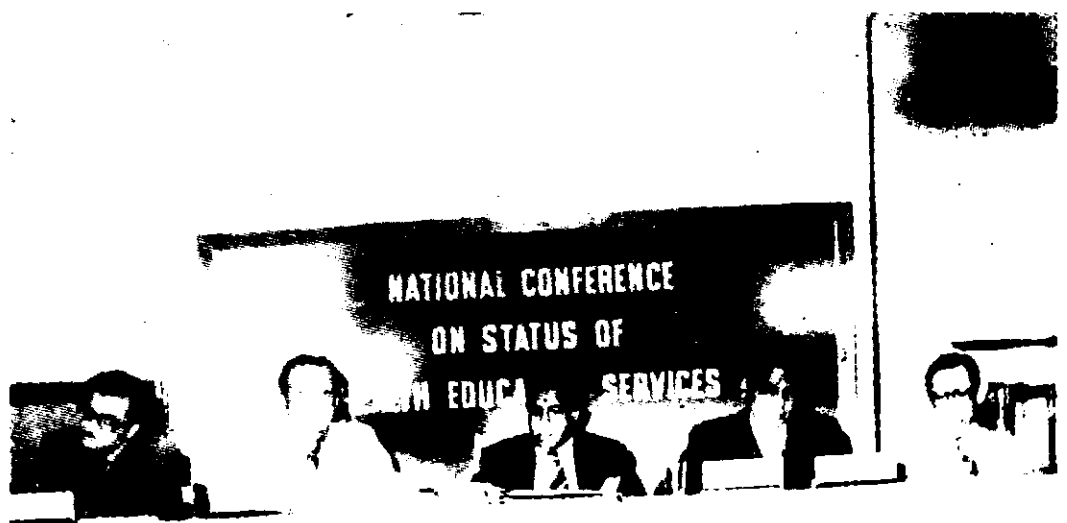


Dr. Ranjit Sen, Deputy Director General of Health Services welcoming the participants at the Valedictory Session.

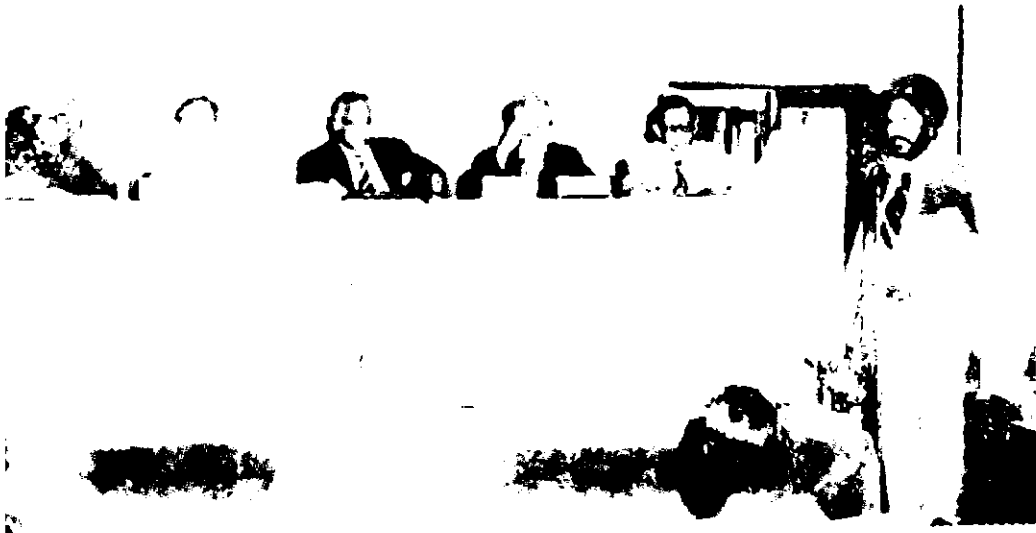


Shri P. Sabhanayagam, Secretary, Ministry of Education and Culture, delivering the Valedictory Address to the 3-day Conference.

Dr. C.H. Piyaratna, Advisor, Health Education, World Health Organization (SEARO), addressing the participants at the Valedictory Session.







Dr. Harcharan Singh, Professor and Head of the Department of PSM, Medical College, Patiala, speaking on behalf of the participants at the Concluding Session.



Dr. B.C. Ghosal proposing a vote of thanks at the Valedictory Session.



A view of the participants at the Concluding Session.

Shri V.N. Kakar, Chief (Media), Department of Family Welfare, gave a detailed background of the communication policy adopted by the Government right from the inception of the Family Planning Programme in 1952. He said that while it was true that there was a media explosion in the country as stated by the Minister of State for Health in his inaugural address at the Conference, this was confined only to the urban areas.

Media, Shri Kakar observed, had limitations and could at best succeed only in creating awareness. They could not, therefore, play a major role in changing behaviour. During the last three years the Department of Family Welfare had taken up the inter-personal approach to promote the programme on the basis of its experience over the years. This, he hoped, would yield good results. Shri Kakar felt that family planning could progress only when there was a balance and compatibility in the development of human personality. He gave the example of Kerala where the general living standards were much higher as compared to other parts of the country. The family planning programme had succeeded to an extent more than anticipated in this State.

## PLENARY SESSION V

### *INSTITUTIONALIZED HEALTH EDUCATION SERVICES*

The second plenary session of the day was devoted to presentations on Institutionalized Health Education Services. Dr. (Smt.) S. Chawla, Principal, Lady Hardinge Medical College, New Delhi, chaired the session.

Dr. C.H. Piyaratna, Regional Advisor in Health Education, WHO, (SEARO) spoke of the development of the health education programmes especially in the developed countries. He narrated experiences of the U.S.A., Canada and European countries where though medicare services claimed a big slice of the government's expenditure, they had not been giving the returns. Then the realization came that the policy makers had "strayed too far away" from health care to specialization and what was really needed was converting hospitals and other institutions from 'disease palaces' to 'health palaces'. This could be brought about only by creating conditions for public to live in good health and this could in turn be brought out by creating health consciousness.

Dr. Piyaratna referred to the Alma Ata Conference with Primary Health Care as the goal. The primary objective of the primary health care, Dr. Piyaratna said, was creating the two-fold consciousness : (1) what shall I do when I am ill, (2) what shall I do to remain well.

Primary health care, he added, covered all areas of health in which people were intimately connected and could contribute. Thus community participation was fundamental to achieving primary health care.

Dr. Piyaratna concluded with the observation that WHO was associated with projects in India where institutionalized health education services had been started. He hoped the programmes would be strengthened in the country.

## **Primary Health Care**

Dr. B C. Ghosal, Director, Central Health Education Bureau, was the second speaker of the afternoon. He presented a paper on primary health care, its concept, objective and role of health education in primary health care.

Dr. Ghosal defined primary health care as "essential health care based on scientifically sound and socially acceptable methods and technology made universally accessible to individual and families in the community through their full participation and at a cost that the community and country can afford to maintain, at every stage of their development and in a spirit of self-reliance and self-determination". He said primary health care formed an integral part of both the country's health system of which it was the central function and contributed to its socio-economic development

Dr. Ghosal said that health education was a fundamental part of primary health care programme. But any health education programme could be successful and effective only when it reached every family and every member in the family. It was the family which had to seek timely help for a sick child, get immunization at the right time and attend to minor ailments.

Speaking of his experiences of implementing rural health programmes, Dr. Ghosal said that the PHC staff "are able to cater to a very small fraction of the population under their jurisdiction". The community health volunteer who belonged to the community and was able to understand them better was likely to be much more effective, acceptable and experiments carried out by a number of voluntary organizations have provided these assumptions to be correct. The CHV can become "the bridge between the PHC staff and the village community".

Concluding, Dr. Ghosal said that the health education strategy should be based on faith in human dignity, an individual's ability in managing his own life, importance of freedom of expression, and solution of problems through self-help.

## **Discussions**

A brief discussion on the presentations followed. One participant said that we should translate our resolutions into action in order to achieve our goal and this should not be a mere academic exercise. Self-reliance in development work was stressed by another participant. One participant said that we should mobilize the resources within the community and added that this experiment had proved very successful in Karnataka. The primary health centres should take part in intensive health education activities and there should be minimum of health education within the existing services.

Dr. Piyaratna said that there were two broad ways through which people learnt about things, *i.e.*, dissemination of information and backing the information with practical experiences. He stressed the importance of dissemination of knowledge through experiences as against mere academic discussions.

Dr. Ghosal informed the gathering that government was always willing to help the voluntary organizations whenever such requests were received.

Dr. Chawla in her concluding remarks said that young medical students were taking great interest in health education work. She said that we always talked of the rural poor, whereas there were lot of people in the urban areas who were equally poor and had no basic facilities. They could be taken care of. She informed that a voluntary discharge unit had been started by the medical students in the hospital where after discharging the patients they were educated on preventive aspects.

The most important need, Dr. Chawla felt, was to achieve a change in the motivation of the people for visiting hospitals. They should come there to keep well and not to be just get treated for some ailment or disease.

## **PLENARY SESSION VI**

### *PRESENTATION OF GROUP REPORTS*

The morning session of the fourth day was devoted to presentation of the four group reports. Dr. B. Sankaran, Director General of Health Services, chaired the session.

After the groups had presented the reports, Dr. Sankaran made a few observations in relation to the reports. He said the Conference should recommend such guidelines that health education work could be carried out right down at the periphery.

The Director General said that it was good to have diploma courses in health education, so that potential health educators were equipped to perform their jobs well. But it was equally important to make all members of health team oriented to health education work. Medical colleges could take the lead in doing this, he said.

Dr. Sankaran said that there was always a large gap between profession and performance. He hoped that the leaders of the preventive and social medicine departments of medical colleges would be sincere and enthuse their colleagues in other departments to introduce a segment of health education in their areas of teaching.

Speaking on development of health education bureaux, the Director General said that the visibility of an institution would be "known best by its performance". CHEB and SHEBs needed to establish themselves to become "felt needs" and "nothing can move or happen without this total involvement", he added.

Dr. Sankaran felt that the child to child programme was a very good vehicle for promoting health education work. This programme, he revealed, had performed 'miracles' in Japan and should form a basic part in school health education work.

The session ended with a vote of thanks proposed by Dr. Ghosal to the Director General.

## **VALEDICTORY SESSION**

The valedictory session of the Conference held in the afternoon of 29 February, was chaired by Dr. I.D. Bajaj, Addl. Director General of Health Services. Shri P. Sabhanayagam, Secretary, Ministry of Education and Culture, delivered the

valedictory address. Dr. Ranjit Sen, Deputy Director General of Health Services, welcomed the distinguished speakers and guests.

In his address of welcome, Dr. Ranjit Sen said that health and education could not be divorced from each other. India was committed to achieve 'health for all' by 2000 A.D. Therefore, having a literate population would help in reaching this goal. Health and healthy living, he said, were a way of life and people could appreciate these concepts only through acquisition of knowledge. In this context, the role of Education Ministry was very apparent. Dr. Ranjit Sen said that health education should be included in school curriculum right from nursery stage up to the adult literacy programmes.

Dr C.H. Piyaratna, Health Education Advisor, SEARO, WHO, in his brief address, stated that the Alma Ata Declaration emphasized a greater role for health education in promoting health. People's participation was vital for success of health programmes and this could be brought about through the educational approach.

Dr. Piyaratna felt that present health education efforts were inadequate, particularly the school health education programmes. While the curriculum was equipped with all applied arts, it had no such emphasis on health matters. "People know more about motor parts than about their bodies."

Dr. Piyaratna said a vast number of diseases in developing countries of SEARO region were preventive in nature and could be controlled by simple preventive measures. Utilizing available knowledge was the cardinal principle of health education.

Dr. Harcharan Singh, Professor and Head of PSM Department in Patiala Medical College, speaking on behalf of the participants, said that the Conference was very timely and useful.

He appealed to the Central and State Governments to "loosen the purse strings" to make it possible to expand health education activities at various levels.

### **Valedictory Address**

In his valedictory address, Shri P. Sabhanayagam, Secretary, Ministry of Education and Culture, said that health education could be compared to environmental education or to cultural education. It was important to know the methodology of imparting this to the community. Equally important to know was the content of education to be given to people. Health education services, he said, should lay emphasis not only on curative and preventive services, they should help the people to become self-reliant.

Shri Sabhanayagam stated that the programmes should suit the needs of the groups for whom they were intended. People came from different economic strata, followed different social customs and beliefs etc. They should, therefore, be thought of only in their individual cultural context. In so far as the country as a whole was concerned, there were, however, certain themes which were common, for example, personal hygiene, cleanliness and clean habits. These had universal

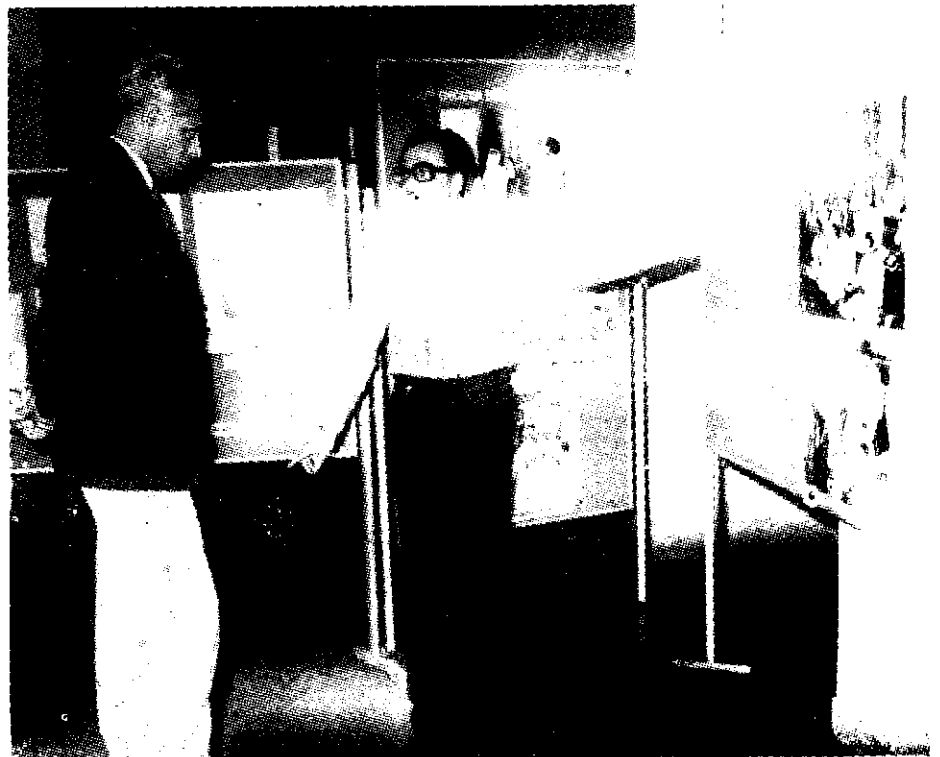
The Bureau arranged an exhibition at the Vithalbhai Patel House to mark the Conference.



Dr. Ghosal explaining a panel to Shri Laskar.



Shri Laskar opened the 'Health Education for Better Health' exhibition.



Shri N.N. Vohra evinced keen interest in the exhibition.

A group photograph along with Shri Sabhanayaga at the exhibition venue.





One of the groups of participants discussing promotion of health education through health professionals.

A Daily Bulletin was brought out every day of the Conference. The Bulletin Team seen giving final shape to one of the issues.



relevance and importance whether a person was young or old, rich or poor, formally educated or not and living in different physical conditions.

Speaking about health education for children, the Education Secretary said that the subject could be taught through the school system by introducing learning materials which would form part of the syllabus and also by the teacher himself arranging for physical exercises, etc., and by keeping a watch over the health of each child.

The Education Secretary said that for five years now, the NCERT had been working in conjunction with the CHEB and developing learning materials and teachers guides. Some States like Tamil Nadu and Gujarat had produced similar materials. Shri Sabhanayagam felt that for those children outside the formal system and for the adults, the concepts of health education could be imparted in close association with those incharge of the education programmes.

Shri Sabhanayagam said that need for health education had grown with the development of societies. If one were to look at the time when man was created and he lived on nature and was attuned to it, there would appear to have been no health problems. Now while persons living in urban, industrial and mining areas were exposed to their peculiar environmental health hazards, the people in the rural areas had their own problems, made complex due to poverty and lack of education regarding health, hygiene and sanitation. Any discussions regarding health education services had to take note of these peculiar environmental and cultural characteristics

Shri Sabhanayagam suggested that available resources with Health and Education Ministeries should be pooled to provide effective services. He asked the health educators to follow the strategy employed in the National Adult Education Programme to achieve better results. A close integration of the health department with other developmental departments and setting-up operationally responsible official machinery at State and District levels would help. Preparation of material for purposes of motivation for learning guidelines for instructors and workers in the fields should be prepared by the State material for identified groups and sectors of population within the State.

Shri Sabhanayagam also stressed the need for publicity to the programmes, committed health educators and periodic monitoring and evaluation of the programme.

Speaking after Shri Sabhanayagam, Dr. I.D. Bajaj, said that in the context of the Alma Ata declaration for providing primary health care to the vast masses of rural population, and the recent signing by India of the Charter for Health Development, the need had accentuated for speedier development of health services. The need was to bring about a basic change in health consciousness among the people, who normally associated hospitals with diseases, suffering, etc.

Dr. Bajaj said that while dramatic rise in health services could not be promised immediately in view of the magnitude of the population, area of the country, etc., people could be made health conscious through education. Preventive



measures could be taught, and preventable ailments kept away. All available media and inter-personal communication procedures could be put to use in this task of education. Children could be immunized, family size planned, etc. Health education could thus assume a major role in the health strategy.

Health education, Dr. Bajaj stated, was not new to this country and this Conference had emphasized this point. The CHEB, established in 1956, had been making sincere efforts to promote the discipline through its own activities and in States and districts and other agencies. The Bureau has worked closely with the Education Ministry to promote health education for children.

Dr. Bajaj hoped that the CHEB would see that the recommendations took a practical shape and give the programme "a major thrust and secure both administrative and financial support".

Dr. B.C. Ghosal proposed a vote of thanks. Dr. Ghosal thanked the World Health Organization, State Health Directorates, Planning Commission, University Grants Commission, National Council of Educational Research and Training, National Institute of Communicable Diseases, All India Radio and Doordarshan Kendra, Municipal Corporation of Delhi, Indian Medical Association, Voluntary Health Association of India, Indian Red Cross Society, Medical Colleges, National Institute of Health and Family Welfare, the Hind Kusht Nivaran Sangh, the Leprosy Mission, All-India Institute of Hygiene & Public Health, Calcutta, Gandhigram Institute of Rural Health & Family Welfare, and the Department of Family Welfare and Ministry of Social Welfare for their support to and participation in the Conference.

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# RECOMMENDATIONS

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The National Conference on Status of Health Education Services in India made far-reaching recommendations for strengthening health education services at different levels in the country. Given below are the consolidated recommendations of the four groups of the Conference.

1. All the different units of the SHEBs and of Union Territories as suggested by the Central Plan should be established wherever they do not exist. Such strengthening is essential as the SHEBs have to start health education programmes in a big way at all levels of health administration.
2. SHEBs should develop and produce health education material suitable to local conditions for all Health and Family Welfare Programmes in close collaboration with the State Mass Media Divisions.
3. The State Health Education Bureaux should be manned by personnel specialized in health education, who have faith in the philosophy of health education and dedicated to the speciality.
4. All health programmes should set apart two per cent of the programme budget to health education and notify the SHEBs about this. This will enable the programmes to get health education support without delay. It was decided in one of the CCH meetings.
5. SHEBs should be given adequate funds in the health budget for media activities including the purchase of films on health subjects.
6. Health Education Bureaux in the States/UTs should work in close collaboration with the AIR/TV/Field Publicity and other I & B Ministry Units and assist in organizing educational programme on health and family welfare to do this work.
7. The SHEBs should work in close collaboration with the State Family Welfare Bureaux to develop health education in health and family welfare programmes to avoid duplication of efforts

8. SHEBs should utilize the health education potentials available in medical colleges, nursing training institutions, etc. (It cited the instance of the three Primary Health Centres to be adopted by each Medical Colleges.)
9. SHEBs should stimulate medical colleges, nursing training institutes, voluntary agencies, home science colleges and such other training institutes to take up action-based research. They should also be used to evaluate the effectiveness of the available health education materials.
10. Health education should become a component in all rural training programmes no matter what aspect of rural development the training deals with. Central, State or District Bureaux/Units should take the initiative in providing the health education components at such training programmes.
11. SHEBs should organize periodic workshops/meetings at different levels of health administration as a medium of continuing education particularly for those engaged in health education and generally for all health workers.
12. CHEB should as an apex body at the National level, provide leadership in the different specialities, such as training, research, media development for communication support, School Health Education and provide health education services to the SHEBs and other organizations.
13. Suitable mechanism should be developed to provide for exchange of information between the States and Union Territories. Inter-State study tours/observation tours must be encouraged and CHEB should coordinate such activities.
14. The infrastructure of the apex Institute should be strengthened so as to shoulder the additional responsibility that accrue consequent upon the intensive health education activities at various levels.
15. The CHEB should continue to develop and produce health education materials till the SHEBs in States/UTs strengthen the media divisions and are in a position to take up the activities.
16. Central assistance or assistance from International agencies, such as WHO, UNICEF could be made available to the SHEBs for promotion of health education materials and for setting up District Health Education Units in a phased manner. Similar assistance may be sought for production of health education materials.
17. The group felt that the number of seats and the training institutions should be decided according to our future requirements which must be estimated at the Centre and State level.
18. The curriculum of DHE is uniform in all the three institutions. Since the last review of the curriculum was done in 1974 there is scope for reviewing it again. It should be periodically reviewed by the institutions jointly imparting this training and modified according to the job requirements.

19. In future the trainers of health educators should possess atleast a Masters Degree in Health Education/Public Health. Such courses should be imparted in selected institutions. In these institutions it should be ensured that adequate facilities are provided to enable students to pursue research work leading to a doctoral degree. It is hoped that with the provision of these courses, trainers will in due time possess doctoral level qualifications. In order to attract good students to the masters programme adequate number of scholarships should be provided.

The Universities may be moved to consider if persons holding DHE and desirous of possessing the Master's Degree programme in Health Education could be given some credit in lieu of the Diploma they already possess.

20. CHEB, NCERT, UGC, SCERT, SHEB, NSS and Directorate of the Adult Education and other agencies may be involved in various training programmes for better and effective coordination.
21. The doctor should essentially have a strong conviction in the precept and practice of health education tools and techniques.
22. For the acquisition of knowledge, right attitudes and proper skills it will be essential that medical education becomes community oriented rather than hospital centred as it is at present. Unless and until atleast one half of the total clinical training of the undergraduate students is carried out in a community centre and setting it will not be possible for him to render effective community health services.
23. Departments of Preventive and Social Medicine in the present day medical colleges are the only departments conducting tangible health education training both in theory and practice to some extent. It, therefore, becomes imperative that health education training component of these departments should be adequately strengthened by establishing a health education unit as envisaged in Medical Council of India recommendation 1970.
24. Health education units should be established in all teaching institutions properly staffed and equipped with A.V. Aids and A.V. aids producing equipment units should have Assistant Professor/Lecturer in health education.
25. Evaluation studies on the impact of health education in the acceptance and use of health services and development of indices for evaluating the educational component of the daily work of all types of health worker should be undertaken.
26. The medical colleges have been given the total responsibility of health care of three community development blocks. These community settings like primary health centres, subsidiary health centres, sub-centres, national health programmes, etc., should be fully utilized for giving a practical training to the students in terms in the science and art of health education To make this training realistic and meaningful the health education services should be organized on the foundations of local morbidity, involvement of local people in formulation and implementation of Community Health Services by allotting

specific tasks to all members of the health teams and to the volunteers of the local leaders.

27. The teaching and training component of health education has to be necessarily strengthened in all clinical departments. The Medical Council of India should spell out more clearly and specifically the responsibilities of all clinical departments for health education training as has been done in case of social and preventive medicine. Unless and until all clinical departments undertake practical demonstration of the importance of health education in all types of clinical practice, health education learning will be impossible. The student will never learn and realize its importance. He must constantly observe health education being practised as an integral part of clinical practice.
28. Health education training around patient care in all situations like an O.P.D. and indoor and special clinics like ante-natal clinic, post-natal clinic, under five follow-up clinics, etc., should be emphasized, specially the importance of building a rapport of positive doctor-patient relationship.
29. Whenever doctors are recruited for the job in the government sectors, general training is being given. This training should include adequate theory understanding and explanation of the actual programme of health education and its implementation and the role the doctor has to play in this regard.
30. For continuing education programme the State Health Education Bureaux of respective states should prepare self instruction material and send them directly to the PHCs and rural dispensaries to keep the young medical officers apprised with the latest knowledge and trend in the field of health education.
31. The programme of training in health education has been well reflected in the recommendations of the Workshop in Development of Integrated Training of Medical Officers of P.H.C. [January, 1980 on Page 21 (Unit II)]. This will be useful in planning the training programme.

### 32. Medico Social Worker

Medico Social Worker is an important health functionary who is vitally concerned with management of total health problems. He plays a pivotal role in information, education and communication of the patient and relatives, family and the community. Thus health education is an important asset through which he practises his profession in a hospital/community situation. For the training in health education he needs to be exposed to long/short-term training. The long-term training will include one year's Diploma in Health Education. And for short-term, three-month certificate course at CHEB may be made essential.

### 33. Nurses Training

There are 124 nursing schools/colleges in India giving training from 2 to 4 years and 160 schools for the training of auxiliary nurse midwives. In most

of these institutions health education does not find a place as a separate subject but is taught alongwith other subjects.

#### **34. Multipurpose Workers Training**

The training of the multipurpose workers is being given in some of the primary health centres and in regional training centres. Most of the training centres have given the suggestions that the trainers for these trainees should be properly trained and well equipped in health education with more refresher courses.

#### **35. Training of Dispensers**

The dispenser can play an effective role as health educator because of his age-old association and identification with the doctor. He is a most accepted member of the health team by the community at large. The dispenser caters to the felt needs of the community for the curative aspect of health care. In the rural setting in many places dispenser is the only person available and as such is very important for dissemination of health education while dispensing the medicine.

#### **36. Training of Technicians/Health Attendants**

It is recognized that technicians and health attendants in a hospital and health centres could be more effective in imparting health education to patients, relatives and visitors because of their regular and immediate contact. They could be a real agents for dissemination of knowledge about existing health facilities and their fullest utilization by people.

It is, therefore, recommended that inservice training of this category should be arranged locally by the SHEBs, hospital staff under the supervision of nursing staff. Wherever health education specialist/department of S.P.M. are available, their technical expertise, support and guidance would prove to be an asset.

#### **37. Training of CHVs and Traditional Birth Attendants**

The most important functionaries recognized for the delivery of primary health care in India, are the community health volunteers and traditional birth attendants who may be trained and enrolled as CHV, females.

The detailed programme of the training have been evolved which included adequate content and stress of health education. It is recommended that the training contents envisaged, should be thoroughly implemented, keeping in mind the local conditions and problems.

#### **38. Training of Professionals/Functionaries practising Indigenous Systems of Medicine**

There is a massive army of these people working in health care delivery system in India both in the Government Sector as well as in a private capacity. Nobody can deny the tremendous faith and confidence people are having in these

**systems and in these people. Faith is fundamental to education and specially in health education. It is recommended that Government should take necessary steps to give adequate component of health education in the formal courses of instruction and also organize small regional/local training camps and workshops.**

### **39. Advance Training**

It is felt that fellowship for advancement of training in the field of health education should be made available more liberally to Central Health Education Bureau/State Health Education Bureaux/Medical Colleges, Departments of SPM/Training Centres in Health Education so as to enable the trainers to keep them abreast with latest developments in health education.

- 40. Exchange programme of personnel of various SHEBs/faculty undertaking teaching training programme should be introduced and stimulated with the financial assistance from Government of India.**
- 41. Refresher and orientation courses of varying duration according to needs and problems should be arranged from time to time by CHEB/SHEBs/other training institutes for all the categories of health workers.**
- 42. Considering the fact that a lot of health education input has already been made in the areas of formal and non-formal school education (for example, NSS and CHEB developed 19 instructional materials for non-formal and NSS volunteers) and feeling the need to strengthen the health education in this sector it is recommended that action may immediately be taken to make an indepth study of the existing instructional materials to ascertain what else is needed for strengthening teacher training of health education concepts in the school health programmes.**

This task may be undertaken by CHEB for the National level instructional materials and by SHEBs for the State-level materials. This task is to be completed as early as possible because all the future action should be based on findings. The collaboration of NCERT and SCERT may be sought in this effort.

- 43. On the basis of the findings and considering the contemporary trends, it is suggested that an approach paper on student health education may be developed jointly by NCERT and CHEB.**
- 44. Necessary steps should immediately be taken to strengthen the student health education services (formal, non-formal, school, universities, NSS) and improve the health condition in the educational institutions. For this purpose it is necessary to explore the possibilities of involving different people (private practitioners, retd. medicos, physicians from other systems of medicines) and agencies (official and voluntary) who have the competence but have not been associated so far.**

45. Curriculum laboratories-cum-resource centres to strengthen the programmes of health education in all systems of education may be set up.
46. Medical colleges may be requested to adopt some schools for health education and health check-up. Medical students can also orient non-medical students.
47. Immediate steps should be taken to upgrade and improve the quality of health education component in the different teacher training programmes (both pre and in-service) and to introduce special degree courses through the education faculty of the universities
48. National Council of Teacher Education may be requested to take necessary action and all agencies (NCERT, Universities) may be requested to improve the health education component in the different teacher training programmes operated by them and also to introduce special courses in health education for Method Masters and Teachers as part of DHE courses introduced at present by Delhi, Madurai and Calcutta universities. CHEB and SHEBs may consider to introduce special inservice training programmes.
49. Necessary steps may be taken to introduce a number of pilot projects in selected areas for :
  - a. identifying the "systems" operating in the particular area, and
  - b. devising an operational model to involve different people and various agencies in improving health education.

CHEB (for National level) and SHEBs (for State level) may take up the responsibilities. As Adult Education Department and NSS Unit of the Ministry of Education and Science Department of NCERT are carrying out similar programmes, these departments may also be associated.

50. CHEB and SHEBs may arrange to set up working groups for the implementation of each recommendation.

Similar follow up actions should be designed for all other activities specially the teachers training programmes.



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## EXCERPTS FROM SPEECHES

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*Shri N.R. Laskar, Minister of State for Health & Family Welfare (26. 2:80) :*

All of you know that recently India signed the World Charter for Health Development. In September 1978, we were also signatory to what is known as the Alma Ata Declaration. Both the Charter for Health Development and the Alma Ata Declaration underscore the importance of health and define the problems which must be tackled in order that man is able to lead a healthy life. There is growing consciousness in the world today, as in India, that health is a fundamental human right and without it whatever other progress man may make, he cannot possibly lead a full life.

What is meant by health ? It does not mean just absence of disease or infirmity. The Alma Ata Declaration defines it as "a state of complete physical, mental and social well-being". Unfortunately, over the years we have developed an attitude of mind which prompts us to think of health only in times of sickness. We have become, if I may say so, medicine-oriented. When we think of the health status of our people, generally we tend to measure it in relation to the availability of hospitals, dispensaries, primary health centres and sub-centres. All these institutions are necessary and need to be expanded further in order that when sickness occurs, it is taken care of promptly. Their expansion is also necessary from the point of view of prevention of sickness, particularly in villages and slums in cities. To prevent and combat sickness is one thing. It is highly important. But more important than all this is the creation of conditions which may be conducive to the normal growth of man as a healthy being with all the essential inputs of health taking him forward in his life's journey.

You as health administrators have a great role to play in this. You must take advantage of the fact that increasing light is being focused on the health needs of man today. This should give you encouragement in carrying forward the process of health education in the community, both through formal and non-formal channels. Wherever health education has not been introduced in schools, it should be induced. Whatever resolutions you may pass on the subject here should find concrete shape in action back home when you go to your States. I believe that if you have closer and regular interaction with the education authorities, the process of health educa-

tion getting its due place in the school system can gather greater substance and speed. Paucity of funds is often cited as one of the basic reasons responsible for inadequate action in this area. That may be true to a certain extent. Funds should be provided for this essential activity. But more importantly, there has to be a proper conditioning of minds. Health administrators as medical personnel generally command greater respect in society than others. I would request that they should give greater thought to health education themselves and try to influence others, particularly educational institutions, to take cognizance of its importance.

Millions of our children do not go to schools. Amongst those who go, a good number drops out within the first two or three years. The child labour force in our country exceeds 10 million. The enormous nature of the problem of exposing out-of-school children to health education need not frighten us. Our country has been witnessing a sort of media explosion during the last many years. I have no doubt that the media can play an extremely useful role in bringing home to the people the fundamental ingredients of health education. It is sad that the media have not been used fully for this purpose. Health Education Bureaux in the States have not used them in the measure expected. Wherever these Bureaux are in existence, they are not taking full advantage of the media resources available to the community. I draw your pointed attention to this aspect of the situation. I would also like to mention that the concept of cleanliness is embedded in the Indian cultural ethos. Even when it is cold, we do not like to miss our bath. For centuries we have used *neem* to keep our teeth clean. These facts need to be taken advantage of. I do not see why with sincerity and greater effort, we should not succeed in making use of the media for promoting health education amongst all.

The question of achieving community participation in health education programmes has been in the limelight in the recent past. You know that it was as a result of the active participation of the community in the smallpox eradication programme that we were able to get rid of this disease from our country. There is no community that does not want to live better. The important thing is that the community should be approached properly to enable it to play its due role in its own uplift. We have now a large force of community health volunteers functioning in villages. These volunteers can promote the positive aspects of health in villages much better than those from outside. They live in the villages in which they function and have a sense of belonging to them. I do hope that the Central Health Education Bureau here and the Health Education Bureaux in the States have devised measures to remain in regular contact with the community health volunteers. I also hope that they are taking advantage of other development functionaries, both official and non-official, in bringing about greater participation of the community in health education programmes. If the people are approached with humility, there is no reason why they should not participate in programmes designed to improve their own welfare. We have seen enough evidence of their wisdom during the last few months.

Even though health is a State subject, I am deeply conscious of the Centre's role in promoting it. The people of India belong to one large family. They get

their strength from one another. If one region suffers, another comes to its rescue. Whether a subject is administered by the Centre or by the State, it is immaterial. We are all participants in the great endeavour to lift the health status of our people. I can assure you that I shall try my level best to persuade the States to give to health a high place in their order of priorities. Whatever we can do from the Centre, we shall do it.

The objective of your Conference starting today is to ensure that the vast masses of our people, including those living in remote areas, understand the concept of proper health, the need for maintaining an environment in which health can be promoted and sustained and the locally adaptable technological or other methods which can help achieve this objective. The message of proper health should get woven into the fabric of our society and of our daily life-styles in homes. This could best be achieved not only by inculcating knowledge and attitudes in the leadership in the community at all levels but more importantly in the growing generations of our country. If the Conference addresses itself to these problems of reaching these people and finds proper approaches therefor, a great milestone would have been achieved.

I wish you all success in your deliberations during the next few days and I have great pleasure in inaugurating the Conference.

*Shri Kripa Narain, Secretary, Ministry of Health and Family Welfare (26.2.80) :*

Recently in the Ministry of Health we had two brain storming sessions. One was on family planning. We had this not only among ourselves in the Ministry but also involved non-governmental people including critics of the programme. We had met to examine the family welfare progress, rather the movement during the past decade, the ups and downs we had, the plus points and the minus points, the mistakes we committed and some of the achievements. We had a similar conference on health.

We have resolved like many other countries in the world, to provide health for all citizens of the country by 2000 A.D. This goal is easy to say, difficult to comprehend and more difficult to achieve. We had in these two sessions persons coming from rural areas as also persons from non-health sectors. We wanted to know from them what this 'Health for All' means.

We also now anticipate the results of the Working Groups which have been set up to enunciate what we think 'Health for All' and Family Welfare movement mean in the country. These homogenous groups will be meeting in the month of April. So it is very appropriate that this Conference on Health Education is being held now. I am very happy about it. But one thing is very certain, whether it is family welfare or health for all, we think too much of government functionaries. We will have to secure participation of all segments of the people, though slight orientation for them may be necessary to prepare them to work for promoting health programmes.

The point is what is health? The WHO has defined health as complete physical, mental and social well-being and not merely the absence of disease or infirmity. This is very ambitious. In fact, the other day I discussed it with the high dignitaries on the health side whether there is any system in the world which will give complete physical, mental and social well-being. I think it is a big definition. This may not be achievable by any system of medicine. They do not claim it. I feel that in the definition of physical and mental well-being, we may add spiritual also. In this context, I think the Sanskrit word 'SWASTHA' is very appropriate, i.e., take care of yourself. This objective cannot be attained unless the persons for whom you are working for know about their health. We are here to help them. The persons should themselves become aware of what they want.

As a matter of fact, the other day, we were discussing the structure of the health system. People do not know about the role of *Gaon Sabhas* for health. The point is what all of us here think about this role. That is why the task of health educators is a very difficult one. Your task is to make the community aware of the fact that they finally have the responsibility for their own health and we are there only to help them on what they want to achieve.

The most important link the community has, will be the Health Committee in the *Gaon Sabha*. The *Gaon Sabhas* cannot meet daily. The link between the health infrastructure and the Health Committee of the *Gaon Sabha* is the community health volunteer. This community health volunteer should be a respectable person in the community and should have some image in the community. He should serve the community 2-3 hours per day and not be a young man seeking employment.

The CHV is not a government servant. He should not be one. The whole concept is different. The day you make him a government servant our objective is defeated. We want to have a representative of the community.

Health and education cannot be given. They have to be imbibed. It is very clear that we have to train health education people in the art of performing health education work. We have to produce literature for them such as guidelines, manuals etc.

Our efforts should not be aimed at providing health education only to our workers of the Health Ministry. Health education orientation is also to be given to trainers of the other sectors. Through training classes, orientation courses, etc., we have to put health education content in their curriculum. How to bring this about in concrete terms? This has to be worked out. If a person who is an agricultural worker, probably an agricultural extension worker, approaches a farmer to tell him how to increase production, he can at the same time talk in a pleasant manner about the family planning concept. While doing so he can explain how his *per capita* income would increase if he has a small family. This can achieve results better than what the whole-time workers can achieve. This is because casual remarks well meant and well said and directed often go deep. Also we can produce literature, guidelines, visual aids, manuals, etc., to improve our communication.

So there are three points-- (1) the community itself is more important and the government machinery is there to help the community; (2) try to prepare guidelines, visuals aids, manuals for the community health workers and for workers in other sectors; and (3) approach other sectors so that they too can promote health and family welfare concept in an effective manner. All of them require different approaches in different specialities. This is not an easy task.

These are some of the thoughts I wanted to share with you. I must say this is a very vital Conference as you, in the States, are really the force and through you we can attain our goals in family welfare programmes and health for all by the year 2000 A.D.

*Dr. B. Sankaran, Director-General of Health Services (29.2.80) :*

I have the impression, I hope I am wrong, that this meeting has become again a specialists Conference and not grass-root-level oriented. And on the very first day, when I had an opportunity to make some remarks, what I had requested was that the Government or the Directorate would like you specialists to provide guidelines to health education at the periphery in a way that is more meaningful to the people. I hope that in some of your discussions you had an opportunity to project this particular viewpoint and would make it a part of the deliberations, because I believe that this is not reflected in any of the four group reports presented.

The first report, for example, deals primarily with upgradation of health education as a speciality. The need for Diplomas, Doctorates, the M.Phil., etc., for health education work is good, but this was not what was expected out of this meeting.

The second group dealt with health professionals. I am happy there were very important Professors of Preventive and Social Medicine in this group because it was stressed to reorient health professionals towards health education. I hope that when these Professors of Preventive and Social Medicine go back to their respective institutions, they would be able to reorient their medical and health colleagues, with courage and convictions to their method of thinking. One of the basic difficulties that all of us have been facing, and I would include myself, trying as I am to become a health professional in the last two years, having been a technocrat before that in the field of orthopaedics, is that there is a very large gap between profession and performance. What we state in public platforms is not necessarily followed up by action when we go back. I do sincerely hope that you leaders in your respective fields of Preventive and Social Medicine would be able to go back and enthuse your colleagues in Medicine, Surgery, Obstetrics, Gynaecology, Paediatrics, etc., to introduce a segment of health education among their respective students.

I would like to give a very small example. I had the opportunity recently to visit one of the medical colleges during the Japanese Encephalitis epidemic in

Karnataka and Andhra Pradesh. There was then a strike in Chittoor (A.P.) and a Head of the Department had to take care of the patients in a hospital. I give credit to that lady for having done a superb job. But unfortunately, Sir, she was not aware of the rehydration therapy through the oral route. And I think there was a very definite lack of communication, and if she is not aware of it, how is she going to educate the students of such a simple oral rehydration formula in diarrhoeal diseases. To give an illustration, the 14th bottle of intravenous fluid was going on to an unconscious child who could easily have been fed with a tube and would have been better off. This is a thing which I believe that you people should carry back. As a matter of fact, tomorrow I am going to be in the Indian Academy of Paediatrics trying to tell about oral rehydration.

Group three had a very difficult task and that was to examine the role of the Central Health Education Bureau and the State Health Education Bureaux and evolve a strategy for organizing community health education activities. I have heard some of the participants mention that this report is not as complete as it should have been. I hope that this is corrected or rectified and brought to normal, but one comment which I may be permitted to make is that about two or three years ago, I myself was not aware of the existence of a Central Health Education Bureau and I do not think it is my fault. I think that the visibility of an individual or an institution is known by its performance. And therefore, I think if you perform then you will get automatic recognition and I think the Central Health Education Bureau and the State Health Education Bureaux have to perform and make themselves as the felt needs of the society. The implication is that nothing can move or happen without this total involvement and I hope that this Conference would be able to put not only health education but the institutions on the map of the country.

And lastly, I had the opportunity to read carefully the report on School Health Education, because it was the last one being presented and I had an opportunity to go through it. I believe, one of the things that has not been touched is the programme which I believe, is a very good vehicle of health education. And that is the child to child education programme. It was mentioned, but it has not been discussed in detail and this is a point that you must consider. I am not a health educator, but I believe I have seen the effects of a child to child health education programme in far away Brazzaville, Congo and also one other African State. This has performed miracles and I believe that this also should be thought of by this Group.

I am sorry if I have tread upon anybody's corns. But it is good to be introspective, and it is good to criticize ourselves and also try to find out where exactly our faults are and try to rectify them. This should be reflected in the reports.

*Dr. C.H. Piyaratna, Regional Advisor in Health Education, World Health Organization, New Delhi (28.2.80) :*

I have been asked to speak on health education in institutions. This being a National Conference, we probably have to start with health education in

institutions in India. In that case, there are people here in the audience who have actually done much work in this country and have gained experience. We are aware of some of these activities and have actually collaborated with them. We now have to see what is happening around the world in this sphere. So before we come to consider what is going on in India let me examine health education in institutions around the world.

When we talk about health education, we have to remember that, for many years, we have limited our activities to health education in the preventive scene. Therefore, much of our health education activities have been carried out during visits to homes by various health workers, in clinics and sometime in the communities. Doctors and others, specially those who are engaged in clinical work, have found little time or opportunity for this work. So health education has particularly remained an area of activity in the preventive field.

Recently, however, there has been a change, particularly in the European countries. Let me take the case of health education in the United States. In the matter of health education of the public, Government had done very little. It was medicare that received emphasis. Medicare organizations with well-organized lobby mechanism were so powerful that social and welfare legislations that would have promoted health education, could not be passed. Medicare was an industry and everybody had to contend with it. But in recent years, U.S.A. found that 15 per cent of that country's G.N.P. was being spent on medicare and 15 per cent is a very large proportion of money for any country. The insurance companies were not willing to pay the medicare bills, not fully in some cases, so the Government had to come forward to pay the bills and it was not possible to do so for ever. This was the beginning of the first serious look on investment in the health field; whether it is wise to keep spending on medicare or on preventive medicine and health education is another matter.

Besides, the Fourth Five-Year Plan for health services in USA was now before the Government. The country could boast of a life expectancy of 72 years. If they continued to invest their health dollars as they had, what would they gain? The realization came that even if they invested more and more on medicare, the life expectancy rate of 72 years would rise by no more than one or two years. They found that they can get much better result from investment on two other activities—behaviour modification and environmental control. Out of sheer necessity the country decided to make larger investment of money on behaviour modification through health education and environmental control. The results are already reflected in the decreased mortality rates due to cardio-vascular diseases and others. For evidence of the impact of education, one has only to witness the people jogging, running, doing all kinds of things, any morning, anywhere in U.S.A. This and other measure together have already brought about a reduction in cardio-vascular disease. So much so that where there was nothing called health education, where the Insurance Companies had only paid for diagnosis and treatment, they are now paying for health education, an intervention which is prescribed in hospital bed-head tickets. So there has been a rapid change from health education in preventive

health services to health education in clinical institutions. And one may ask the question : how better can one manage patients with diabetes, heart diseases, cancer and other chronic diseases where management so much depends on what the patient does for himself, by himself. Doctors and nurses can do a lot, but in the long run, it is the patient who has to think for himself.

Thus we see that American Hospital Association is in the lead for health education in hospitals. Insurance companies are paying for hospital health education and a new breed of health educators called clinical health educators, are being trained in the United States. I mention this to indicate that there is a change. Hospital which were often called diseases palaces are gradually becoming concerned with health also.

In Canada too, there has been a similar review of investment patterns on health care. They had been concerned with the fact that they were spending more and more on medicare and getting less and less in terms of actual health benefit for the people. The Mark Leyland report which looked into this stressed the need to get greater returns for the money spent on health care. They proposed a number of strategies which largely hinged on the area of education of the people, realizing that health ultimately depends not on physicians, nurses or health educators but on what people do and do not do by themselves, for themselves. Yesterday our Secretary to the Ministry of Health referred to this as 'SWASTHA'. After all, health is a matter for individuals. All that we can do is to provide information, motivation and skills to people so that they are able to look after themselves.

A third set of circumstances leading to the development of health education has recently occurred in European countries. The increasing expenses on medicare have revealed to them that medicare alone is unable to deal with peoples' problems. Besides there is increasing criticism about the countries' predominant preoccupation with medicare. A stage has come when they are asking themselves. How shall we spend our health dollar ? Invariably they came to the conclusion that they have strayed too far from the real and essential realms of medicine to advanced technology which they could hardly afford, and in terms of national needs, hardly justifiable. The expenditure on health services is totally out of proportion to other social welfare activities. The various committees set up by these countries have stressed the need to shift their emphasis to preventive care.

More recently the problem of providing health care to underserved and unserved populations of the world was discussed at Alma Ata in USSR. Representatives from all countries of the world who assembled there sought an answer to the question : how can we bring basic health services to the people. They decided on primary health care about which Dr. Ghosal is going to talk. Essentially Primary Health Care is an answer to two basic problems—what shall I do when I am ill and what shall I do in order to remain well. Be it a question about maternal and child care, control of communicable diseases, nutrition, environmental health and the like, it always is one which intimately concerns people and they must do things for themselves by their own efforts. The Alma Ata meeting decided that



fundamental to primary health care is community participation. How do you get community participation? It can only be secured by educational means. People talk about community participation. But it cannot happen automatically. This realization has led to an increasing stress on health education and community oriented medical education and training programmes. To keep up with this growing trend, we in the South-East Asian countries, particularly in India, have initiated health education in hospitals and other clinical institutions. Fortunately we have had people like Dr. Chawla who are willing to take the idea, work it out in their institutions and make something out of it and share this experience with colleagues in other States. As you know, we have had a National Conference on Hospital Health Education, and guidelines have been developed and other workshops are being held in the States. Much more has to be done.

I want to say that the beginning is already there, but it is only a beginning and much more has to be done in your country and by your own efforts. The Health Education Bureau has to act as an important resource. Ultimately the idea is that the hospital should not be a place for patients only but a place for education also. In other countries too, something is happening. In Thailand, Sri Lanka, Indonesia and many others, they are beginning to go into health education in hospitals and other clinical institutions. In Nepal, a small country, where medicare is very expensive in terms of their national budget, where doctors are few, and where doctors are educated outside the country, they have thought about health education. There they have instituted a Diploma Programme in General and Community Medicine and not a M.B.B.S. Programme. In this Diploma programme physicians are given intensive training in behavioural sciences, health education, nutrition and the like in the first place. These are essential and relevant to the needs of the under-developed countries where the majority of the population live in rural area. Their health problems are very similar to that of many other countries in the region and we in WHO are trying in various ways to collaborate with them and to promote health services. We are trying to train the physician who will serve as the leader in the health team, and they will continue to be the leader for many years. We are trying to help them develop basic skills in education, so that they will undertake educational work and, what is more, call upon their staff to do likewise.

These are some thoughts I wanted to share and I hope that these would give you an idea of what is happening in the field of health education in the clinical and other institutions. I hope it will enable you to consider appropriate recommendations for strengthening your efforts about health education in institutions in your own country.

*Shri P. Sabhanayagam, Secretary, Ministry of Education and Culture (29.2.80) :*

I am glad I was asked by my very good friend Dr. Sankaran, Director-General of Health Services, to address those in charge of Health Education Services. In a manner of speaking, I would probably have preferred to have addressed you during the course of your deliberations rather than deliver a valedictory address. If I am to explain myself, the fact is that I am no expert in health education and therefore what I would be saying would be more with reference to my experience as an

administrator and as a member of the public. Following what I have said now, I feel that such questions and suggestions which I would be making would have had direct relevance to the deliberations of your Conference.

Health education can be compared to environmental education or to cultural education. How do we impart them? I had the occasion to deal with environmental education and cultural education and I would like to give you the benefit of that experience for I feel it would be relevant for health education also. The question we should ask ourselves is "what is this education; for whom are we providing the services; why do we have to provide the services; how can the services be provided; how do we measure the success of the services; and what steps should be taken from time to time to improve". Let us take the first one: What is this education we are seeking to give? It would not be for me to explain this for as I mentioned earlier I am not an expert. Each one of you present here is aware and knows much more than I do as to what health education is. I would, therefore, contend myself by saying that in the context of health education services, the emphasis should not be on the curative, or even merely on preventive services. It has to be on helping the people to learn about what is involved in self-reliant health care.

The next question is for whom are we providing services? It is generally said that it is meant for the people. But the people are of different age groups living in different physical conditions, belonging to different economic strata, following different social customs, having certain beliefs, etc. In other words, the people cannot be thought of except in their individual cultural context. Therefore, we cannot think of health education as something which is common for all people, it has to be culture specific; and we would have to identify sector by sector. In so far as the country as a whole is concerned, there are, however, certain themes which are common, for example, personal hygiene, cleanliness and clean habits. This is of universal relevance and importance whether a person is young or old, rich or poor, formally educated or not and living in different physical conditions. For those children going into the formal system of education, health education can be imparted through the school system by introducing learning materials which will form part of the syllabus and also by the teacher himself arranging for physical exercises, etc., and by keeping a watch over the health of each child. For the last five years, the NCERT has been working in conjunction with the CHEB and have produced learning materials and teachers guides. Some of the States like Tamil Nadu and Gujarat have also produced similar material based on NCERT publications. The teachers have been trained in five centres, so also teacher educators so that other teachers can be trained in due course. When it comes to those outside the formal system, in the context of the non-formal education that is being imparted, both to the school-age going group and to the adults, concepts of health education can be imparted in close association with those incharge of the education programmes. For those who are working in industrial units and factories, the organization of providing education to these categories would have to be different. I do not think that sufficient attempts have been made to improve the health of those working in offices and factories. My mind goes to what is said to be obtaining in Japan where

at fixed timings for about ten minutes every one in the office at the seat where he suspends work and goes through a few exercises. What I am trying to bring home to you is that the fact that you have to identify the particular target population for whom health education is meant for and prepare special programmes, both learning materials and associated activities.

How has this problem of health education arisen? If one were to look at the time when man was created and one lived on nature and was attuned to nature, there would appear to have been no health problems. Over the centuries on account of community living, spread of civilization leading to urbanization and industrialization, health problems have become a major issue. While persons living in urban, industrial and mining areas are exposed to their peculiar environmental health hazards, the people in the rural areas have their own problems, made complex due to poverty and lack of education regarding health, hygiene and sanitation. Any discussion regarding health education services has to take note of these peculiar environmental and cultural characteristics.

I have gone through some of the documents which have been prepared for this conference and the impression that I got is that the administrative set-up to provide health education services is most inadequate. While on the one hand all steps should be taken to impress on the authorities that there should be a greater appreciation of the need for strengthening the health services, I am not at all sure, considering the various competing claims, to what extent there would be significant improvement. The question, therefore, arises: What do we do? Do we sit back and throw up our hands? I am sure all of you are made of sterner stuff than that and can together devise ways and means of making your organization effective. Having been in government service for a considerable time, I am more than aware how departments of government function in isolation. There is too much compartmentalization. I am also aware to what little extent the community involvement is understood and accepted. We have had similar problems in the context of the formulation of adult education programme. Based on that experience I would commend the strategy employed in NAEP for your consideration. Attention would have to be directed at motivating the people as a whole, by ensuring the full backing of government and all political parties and other mass organizations by ensuring a close integration of the Health Departments with other developmental departments and by setting up operationally responsible official machinery at State and District levels. To fulfil this purpose just one organization in Delhi cannot fulfil the task. Counterpart institutions would have to be set up in the States. I am aware many States have already done so but in those States which have still not done so, they should be exhorted too. The preparation of material for purposes of motivation for learning guidelines for instructors and workers in the field would all have to be prepared by the State Resource Centres keeping in view of the need for specific relevant material for identified groups and sector of population within the State. For purposes of awareness and the need for health education among the people as a whole as mentioned earlier there should be a concerted effort particularly through the mass media and this would require preparation of software in conjunction with those incharge of mass media.

There is another aspect, namely, legislation and enforcement. We are all aware of the laws passed in regard to adulteration. Based on the judgements of the law courts, you would observe that many cases have failed either because the law is defective or because of the investigation. Even in cases where a conviction is obtained, penalty is very nominal. The local bodies who are primarily concerned with adulteration and with public health and sanitation, do not realize how remiss they are in not fulfilling their functions. Perhaps even the courts of law do not see the magnitude of the danger of adulteration and the need for deterrent sentences. Hence a certain amount of publicity and education of the local bodies would be necessary.

There should be a total involvement of the persons engaged in the services and it should not become a routine impersonal programme. I think many of you would subscribe to the feeling that persons engaged in curative side have all the glamour whereas those engaged in health education do not enjoy that status. Therefore, all the more reason why the persons selected and recruited for these services should have an aptitude for working with the community. There is no point in recruiting people from outside a particular community and basing him to work in the community.

Lastly, before I finish there should be a method of monitoring and evaluating. Unless this system is an integral and inbuilt part of your programme, at no point of time would you know the impact of your efforts and where improvements are called for.

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How has this problem of health education arisen? If one were to look at the time when man was created and one lived on nature and was attuned to nature, there would appear to have been no health problems. Over the centuries on account of community living, spread of civilization leading to urbanization and industrialization, health problems have become a major issue. While persons living in urban, industrial and mining areas are exposed to their peculiar environmental health hazards, the people in the rural areas have their own problems, made complex due to poverty and lack of education regarding health, hygiene and sanitation. Any discussion regarding health education services has to take note of these peculiar environmental and cultural characteristics.

I have gone through some of the documents which have been prepared for this conference and the impression that I got is that the administrative set-up to provide health education services is most inadequate. While on the one hand all steps should be taken to impress on the authorities that there should be a greater appreciation of the need for strengthening the health services, I am not at all sure, considering the various competing claims, to what extent there would be significant improvement. The question, therefore, arises: What do we do? Do we sit back and throw up our hands? I am sure all of you are made of sterner stuff than that and can together devise ways and means of making your organization effective. Having been in government service for a considerable time. I am more than aware how departments of government function in isolation. There is too much compartmentalization. I am also aware to what little extent the community involvement is understood and accepted. We have had similar problems in the context of the formulation of adult education programme. Based on that experience I would commend the strategy employed in NAEP for your consideration. Attention would have to be directed at motivating the people as a whole, by ensuring the full backing of government and all political parties and other mass organizations by ensuring a close integration of the Health Departments with other developmental departments and by setting up operationally responsible official machinery at State and District levels. To fulfil this purpose just one organization in Delhi cannot fulfil the task. Counterpart institutions would have to be set up in the States. I am aware many States have already done so but in those States which have still not done so, they should be exhorted too. The preparation of material for purposes of motivation for learning guidelines for instructors and workers in the field would all have to be prepared by the State Resource Centres keeping in view of the need for specific relevant material for identified groups and sector of population within the State. For purposes of awareness and the need for health education among the people as a whole as mentioned earlier there should be a concerted effort particularly through the mass media and this would require preparation of software in conjunction with those incharge of mass media.

There is another aspect, namely, legislation and enforcement. We are all aware of the laws passed in regard to adulteration. Based on the judgements of the law courts, you would observe that many cases have failed either because the law is defective or because of the investigation. Even in cases where a conviction is obtained, penalty is very nominal. The local bodies who are primarily concerned with adulteration and with public health and sanitation, do not realize how remiss they are in not fulfilling their functions. Perhaps even the courts of law do not see the magnitude of the danger of adulteration and the need for deterrent sentences. Hence a certain amount of publicity and education of the local bodies would be necessary.

There should be a total involvement of the persons engaged in the services and it should not become a routine impersonal programme. I think many of you would subscribe to the feeling that persons engaged in curative side have all the glamour whereas those engaged in health education do not enjoy that status. Therefore, all the more reason why the persons selected and recruited for these services should have an aptitude for working with the community. There is no point in recruiting people from outside a particular community and basing him to work in the community.

Lastly, before I finish there should be a method of monitoring and evaluating. Unless this system is an integral and inbuilt part of your programme, at no point of time would you know the impact of your efforts and where improvements are called for.

# **GROUP REPORTS**

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## REPORT OF GROUP I

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*Subject :* Report on Training of Health Education Specialists.

The Group consisted of the following members :

1. Dr. C. Acharya	<i>Chairman</i>
2. Dr. (Smt.) Sumathy S. Rao	<i>Rapporteur</i>
3. Shri R.K. Chhabra	<i>Member</i>
4. Dr. Harish Grover	-do-
5. Dr. P.V. Gulati	-do-
6. Dr. G.D. Dutta	-do-
7. Mr. P. Shanmugam	-do-
8. Dr. S.H. Hassan	-do-
9. Shri B.D. Chandola	-do-
10. Shri P.N. Khosla	-do-
11. Dr. (Smt.) Lois Philip	<i>Resource Person</i>
12. Dr. N.N. Biswas	-do-
13. Dr. K.S. Sinha	-do-

The Group members met on 26, 27 and 28 February, 1980 and discussed the following points in relation to Health Education Specialists in India. The Group limited itself to the guidelines that had been provided by the CHEB.

The Group took stock of the position of the training status of the health educators and was informed that three institutions, namely, Central Health Education Bureau, New Delhi, All-India Institute of Hygiene & Public Health, Calcutta, and Gandhigram Institute of Rural Health and Family Welfare, Gandhigram, are imparting training to health educators and awarding the Diploma in Health Education (DHE).



So far, nearly 1000 health educators have been trained and most of them are in position. Though a number of health educators working in the field are yet to go for formal training leading to the Diploma, the Group recommended that in future all the new recruits for the post of Health Educators should be Diploma Holders. A time-bound programme may be given to clear the backlog and train the personnel who are working in health education position and are not at present Diploma holders.

The Group was informed that a minimum qualification to join the Diploma Course was Graduation (Bachelor's Degree) with 2-3 years experience. The Group felt that the minimum qualifications should be a Bachelor's degree, so as to enable fresh persons to apply.

The Group felt that the number of seats and the training institutions should be decided according to future requirements which must be estimated at the Central and State levels.

The Group reviewed the curriculum of the DHE and found that it was uniform in all the three institutions. Since the last review of the curriculum was done in 1974, the Group felt that there was scope for a fresh review. It also recommended periodic review jointly by the institutions imparting the DHE training in order to modify the curriculum according to the job requirements.

The Group also felt that it was essential to have continuing education for the Diploma holders who are already on the job. The refresher course (Staff College) must be attended by a person before he is recommended for promotion to a selection grade. This continuing education should be an essential qualification for all health education staff in service.

In future, the trainers of health educators should possess atleast a Master's Degree in Health Education/Public Health. Such courses should be imparted in selected institutions. In these institutions it should be ensured that adequate facilities were provided to enable students to persue research work leading to a doctoral degree. It is hoped that with the provision of these courses, trainers will in due time possess doctoral level qualifications. In order to attract good students to the masters programme, an adequate number of scholarships should be provided.

The Universities may be moved to consider if persons holding DHE and desirous of possessing the Master's Degree Programme in Health Education could be given some credit in lieu of the Diploma they already possessed.

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## REPORT OF GROUP II

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*Subject :* Report on Health Professionals

The Group consisted of the following members :

1. Dr. Harcharan Singh	<i>Chairman</i>
2. Shri G.G. Saxena	<i>Rapporteur</i>
3. Dr. P.N. Sehgal	<i>Member</i>
4. Shri T.R. Bhasin	-do-
5. Smt. Leila Singh	-do-
6. Shri S P. Nigam	-do-
7. Dr. S.P. Mehta	-do-
8. Dr. J.S. Chauhan	-do-
9. Dr. L.M. Murry	-do-
10. Dr. R.M. Bali	-do-
11. Dr. B.M. Dutta	-do-
12. Shri R.S. Sawhney	-do-
13. Shri D. Lakshminarayan	-do-
14. Shri R.N. Dev Sharma	-do-
15. Dr. J. Tariang	-do-
16. Shri O.P. Kapoor	-do-
17. Shri P.S. Bawa	-do-
18. Dr. J.R. Bhatia	<i>Resource Person</i>
19. Dr. A.K. Chakaraborty	-do-
20. Shri G. Narain	-do-

The Group categorised health professionals in two settings, *i.e.*, the hospital and the community.

The health workers in hospital included the doctor, the nurse, the pharmacist, the medico-social worker, the dietician, the hospital technician and the attendant. The community included the doctor, the health supervisor (male and female), the multipurpose health worker (male and female), the traditional birth assistant and the community health assistant.

The Group decided to review the training of various health personnel at different periods with reference to health education component. The assignment should cover objectives, contents, methodology, time allotted for theory and practice, teaching faculty and methods of evaluation, the present status and scope for future development.

### **Medical Officers**

The basic doctor trained in India and expected to man health services as well as general practices would have four important functions to do.

1. Clinical assignment.
2. Managerial assignment.
3. Team leader assignment, a leader of the health team.
4. Advisory role for the bureaucrats and politicians.

The Group kept in view that future placement of a basic doctor graduating out of a medical college is going to be placed in the primary health centres in the State or in general practice. Total planning of content of health education component in this education is being proposed so that it can be effectively discharged as assigned.

In this regard, the recommendations of the Group are as follows :

The doctor should essentially have a strong conviction in the precept and practice of health education tools and techniques.

For the acquisition of knowledge, right attitudes and proper skills it will be essential that medical education becomes community-oriented rather than hospital centres as it is at present. Unless and until atleast one half of the total clinical training of the undergraduate students is carried out in a community centre and settings it will not be possible for him to render effective community health services.

Departments of Preventive and Social Medicine in the present day medical colleges are the only departments conducting tangible health education training both in theory and practice to some extent. It, therefore, becomes imperative that health education training component of these departments should be adequately strengthened by establishing a health education unit as envisaged in Medical Council of India recommendations of 1970.

Health Education units should be established in all teaching institutions, properly staffed and equipped with A.V. aids. The A.V. aids units should have A.P./Lect. in health education, health educators, social scientists, artist, photography unit, material/money and space.

Health Education units should organize regular educational activities in the hospital. They should also undertake inservice training of all hospitals/health centres functionaries on the precept and practice of health education.

This unit should also undertake small research projects in health education. Some of the areas are as follows :

- Study of the community in relation to local beliefs, customs, traditions, practices pertaining to human reproduction, pregnancy, breast feeding, abortion, confinement, care of the newborn, immunization, nutrition, waste and excreta disposal, personal hygiene, causation, prevention and treatment of common diseases and how they affect the health status of people.
- Study of community leadership, decision making process.
- Study of channels of communication.
- Experimental studies on the relative effectiveness of various educational approaches, methods and communication media.
- Evaluation studies of the impact of health education in the acceptance and use of health services.
- Development of indices for evaluating the education component of the daily work of all types of health worker.
- Experiments in the construction of curricula so as to build values or change behaviour in programmes dealing with Health and Family Life Education.

The medical colleges have been given the total responsibility of health care of three community development blocks. These community settings like primary health centres, subsidiary health centres, sub-centres, national health programmes, etc., should be fully utilised for giving a practical training to the student interns in the science and art of health education. To make this training realistic and meaningful the health education services should be organized on the foundations of local morbidity, environment of local people in formulation and implementation of Community Health Services by allotting specific tasks to all members of the health teams and to the volunteers of the local leaders.

The total education process in India is examination-oriented. This cannot be denied. The examination in preventive and social medicine which includes training in health education is conducted at the second professional level as recommended by the M.C.I. up to this stage, both the education and evaluation are futile. The principle and practice of health education can only be evaluated when the student

actively undertakes the practice of medicine and as such it is strongly recommended that examination in Social and Preventive Medicine including health education should be conducted at the final professional level when the student is at a stage to appreciate the role of health education in the total management of health and disease problems.

The teaching and training component of health education has to be necessarily strengthened in all clinical departments. The Medical Council of India should spell out more clearly and specifically the responsibilities of all clinical departments for health education training as has been done in case of social and preventive medicine. Unless and until all clinical departments undertake practical demonstration of the importance of health education in all types of clinical practice, health education learning will be impossible. He must constantly observe health education being practised as an integral part of clinical practice.

Health education training around patient care in all situations like an O.P.D. and indoor and at special clinics like ante-natal clinic, post-natal clinic and under five clinics, follow-up clinics, etc., should be emphasised, specially the importance of building a rapport of positive doctor-patient relationship.

Whenever doctors are recruited for the jobs in the Government sectors, generally training is being given. This training should include adequate theory, understanding and exploration of the actual programme of health education and its implementation and the role the doctor has to play in this regard.

For continuing education programme, the State Health Education Bureaux of respective States should prepare self instruction material and send these directly to the PHCs and rural dispensaries to keep the young medical officers apprised with latest knowledge in the field of health education.

The programmes of training in health education has been well reflected in the recommendations of Workshop in Development of Integrated Training of Medical Officers of PHC, January, 1980 on page 21 (Unit II). These will be useful in planning the training programme.

### **Medico-Social Worker**

Medico-Social Worker is an important health functionary who is vitally concerned with management of total health problems. He plays a pivotal role in information, education and communication with the patient and relatives, family and the community. Thus, health education is an important asset through which he practises his profession in a hospital/community situation.

#### ***Pre-Placement***

A medico-social worker during his training in medical and psychiatric social work and community organization techniques and public relations should be adequately exposed to health education principles, techniques, methods, use of simple and effective audio-visual aids, health education in hospital and home, job

responsibilities of various functionaries and communication and mass media techniques and health education research.

The time allotment should be at least 20 hours for theory and 40 hours for practical placements and training.

### ***Placement Training***

When the medico-social worker is posted in a hospital setting he further needs to be made fully conversant with the latest trends and developments in Hospital Health Education activities.

He needs to be exposed for health education training of long/short-term duration.

#### ***Long-term***

Diploma in health education on seniority-cum-merit basis.

#### ***Short-term***

Three month's Certificate Course from CHEB.

### ***Refresher and Orientation Courses***

One week/short courses could be taken up for two weeks by the State Health Education Bureaux. The contents of this course can be worked out with the local demands/needs.

### **Nurses**

There are 124 nursing schools colleges in India giving training, from two to four years and 160 schools for the training of auxiliary nurse midwives. In most of these institutions health education does not find a place as a separate subject but is taught alongwith other subjects. In those institutions where it has a separate subject the method of teaching is by :

1. Lectures/group discussions, seminars and individual and group assignments;
2. Practicals in the form of preparation of various types of educational aids;
3. Field experiences in primary health centres, home visits, etc.
4. Educational aids being used in the form of printed material, A.V. aids, charts, posters, folders, flip charts, flash cards, flannel-graphes models, puppets, slides, etc.

### ***During the Training***

1. The objectives of training in health education in behavioural terms should be well-defined and properly evaluated.
2. The training should be community-oriented more in field and in classroom.
3. Health education should be included as separate subject.

## **Multipurpose Workers**

The training to the multi-purpose workers is being given in some of the primary health centres and in regional training centre. Most of the training centres have given the suggestions that the trainers for these trainees should be properly trained and equipped with more literature in health education should be given to them and there should be more refresher courses.

The objectives should be clearly and precisely defined as :

1. They should be able to tackle common barriers which interfere in communication.
2. They should be able to identify the opportunities for health education.
3. They should be able to identify community resources and state how these can be utilised for health programme.
4. They should be able to discuss with individuals and small groups about prevention and control of diseases, immunization, how to keep mothers healthy, family planning and medical termination of pregnancy and nutrition.
5. They should be able to identify community leaders and work with them.
6. They should be able to list the simple aids for health education and their use and conduct/discuss informal group at a topic related to health and family welfare.
7. Continuing education in the form of refresher courses, conferences and guidance by supervisors should be done.

## **Dispensers**

The Group recognised the importance of dispensers who can play an effective role as health educators because of age-old association and identification with the doctor. The next most accepted member of the health team by the community at large is the dispenser who caters to the felt needs of the community and the curative aspect of health care.

The Group strongly recommended that the strong component of health education should be included in the one-year training course. At least 50 hours (20 didactics and 30 practicals) should be devoted to the area of health education and its scope and practical application of community health education while dispensing the medicine, the dispenser can undertake effective health education on the curative management of disease as a nucleus and build a comprehensive positive health education programme specially so in the rural setting where in many places dispenser is the only person available and as such is important.

## **Technicians/Health Attendants**

The Group recognised that technicians and health attendants in a hospital and health centre setting could be more effective in imparting health education to

patients, relatives and visitors because of their regular immediate contacts. They could be a real agent for dissemination of knowledge about existing health facilities and their fullest utilization by people.

It is, therefore, recommended that inservice training of this category should be arranged locally by the hospital staff under the supervision of nursing staff. Wherever health specialist/Department of Social and Preventive Medicine are available, their technical expertise, support and guidance would prove to be an asset.

### **CHVs and Traditional Birth Attendants**

The most important functionaries recognised for the delivery of primary health care in India are the community health volunteers and traditional birth attendants who will be trained and enrolled as CHV females.

The detailed programme of the training has been evolved which includes adequate content and stress on health education. The group recommended that the training component of these workers and the training contents envisaged, should be thoroughly implemented, keeping in mind the local condition and its problems.

### **Professionals/Functionaries practising Indigenous Systems of Medicine**

The Group felt that there is a massive army of professionals, functionaries working in health care delivery system in India both in the Government Sector as well as in private capacity. Nobody can deny the tremendous faith and confidence the Indian people had in these systems as well as in these people. Faith is fundamental to education and specially in health education.

The Group recommended that Government should take necessary steps to give adequate component of education in the formal courses of instruction and also, organize small regional/local training camps and workshops for these functionaries.

### **Other Recommendations**

The Group recommended that fellowship for advanced training in health education should be more liberally provided to State Health Education Bureaux/ Social and Preventive Medicine Departments of Medical Colleges, Training Centres in Health Education so as to enable the trainees to keep themselves abreast with latest developments in the field.

Exchange programme of personnel of various SHEBs/faculty undertaking teaching and training programmes should be introduced and stimulated with the financial assistance from the Government of India.



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## REPORT OF GROUP III

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*Subject :* Community Health Education and Central and State Health Education Bureaux.

The Group comprised the following members :

1. Smt. A. Pandit	<i>Chairman</i>
2. Shri Augustine J. Veliath	<i>Rapporteur</i>
3. Smt. Annakutty Roche	<i>Member</i>
4. Smt. K. Sipra Ray	..
5. Shri Jitendra Tuli	..
6. Shri C.C. Gandhi	..
7. Dr. Y.L. Vasudeva	..
8. Shri N.L. Kumar	..
9. Shri. Narayan Chaudhory	..
10. Shri B R. Bhandulla	..
11. Dr. M.C. Verma	..
12. Smt. Sarwat Sanjar	..
13. Shri Subbagowda	..
14. Dr. V.M. Bagley	..
15. Shri T.K. Parthasarathy	<i>Resource Person</i>
16. Dr. (Kum) S.A. Pandit	..
17. Shri K. Balasubramanyam	..
18. Dr. S.K. Selukar	..

The task assigned to Group III were :

1. To examine the role of the Central Health Education Bureau and the State Health Education Bureaux in promoting health education programmes, and
2. To evolve a strategy for organizing community health education activities.

The Group strongly reaffirmed that people have a right and responsibility to participate individually and collectively in health and family welfare programmes. In the light of this, health education is the most important component of health

and family welfare services. The Group felt that all health workers have an educational role to play in the delivery of health and family welfare services.

The Group considered the report of Status of Health Education and noted that the existing organizational set-up at many SHEBs and the District Health Education Units had to be strengthened so that health education became an important part of all health and family welfare programmes.

The Group had a stimulating discussion on the different aspects of the issue involved, training/orientation for officials and non-officials; studies needed for organizing community health education programmes as well as the need of different types of media, their development, pretesting, production and evaluation of the programme as well as different media needed for providing communication support.

The Group identified the Community Health Volunteer as a potent factor in taking health information to the people. It felt that the following groups should also be involved in health education, *i.e.*, members of panchayats, *mahila samaj*, youth organizations, trade unions, voluntary agencies, teachers, formal and non-formal leaders, ex-service men, para-medical workers and medical practitioners.

All these functionaries should be given training/orientation in personal hygiene, water supply and sanitation, prevention and control of diseases, health promotion, MCH and small family norm. They should also be trained in the effective use of different types of media. The training/orientation should be designed, planned and conducted at the PHC levels.

The Group called for the revival of health committees in the rural areas and felt that the CHV can take up this responsibility.

All out effort should be made to use local talent, such as folk singers, puppeteers, *Yakshagana* Troups, *Harikatha*, *Barukatha*, etc., at the village and block levels to further the health and family welfare education activities.

At the PHC and Block level, they should also receive a regular flow of inexpensive display/printed materials and ideas for producing 'material with local resources.

It was suggested that all imaginative and low cost ideas originating at the grass-root levels be identified and publicised through State level magazines and journals. At the national level, every year at least ten such initiatives should be identified and awarded prizes.

Orientation and training should always emphasise the appropriate use of various educational materials. As one member quipped "Best medium is often killed by wrong use".

There should also be periodical evaluation on the use of the material and their effectiveness.

The Group recommended that :

1. Persons trained in health education should be utilized properly to further the cause of this speciality.
2. The State Health Education Bureaux should be manned by personnel specialised in health education.
3. All the different units of the SHEBs and of Union Territories as suggested by the Central Plan should be established wherever they did not exist.
4. SHEBs should develop and produce health education material suitable to local conditions for all health and family welfare programmes in close collaboration with the State Mass Media Divisions.
5. Central assistance from international agencies such as WHO and UNICEF should be made available to the SHEBs for promotion of health education materials and for setting up district Health Education Units in a phased manner. Similar assistance may be sought for production of health education materials.
6. The SHEBs should work in close collaboration with the State Family Welfare Bureaux to develop health education and family welfare programmes to avoid duplication of efforts.
7. SHEBs should organize periodic workshops/meetings at different levels of health administration as a medium of continuing education particularly for those engaged in health education and generally for all health workers.
8. SHEBs should utilise the health education potential available in medical colleges nursing training institutions, voluntary agencies, etc., and stimulate action based on research studies.
9. SHEBs should stimulate medical colleges, nursing training institutes, voluntary agencies, home science colleges and such other training institutes to take up action based research. They should also be used to evaluate the effectiveness of the available health education materials.
10. All health programmes should set apart two per cent of the programme budget to health education and notify the SHEBs about this. This will enable the programmes to get health education support without delay. (In one of the CCH meetings it was decided).
11. Suitable mechanism should be developed to provide for exchange of information between the States and Union Territories. Inter-State study tours/ observation tours must be encouraged and CHEB should coordinate such activities.

CHEB should, as an apex body at the National level, provide leadership in different specialities, such as training, research, media development for communication support, school health education and provide health education services to the SHEBs and other organizations.

The infrastructure of apex Institute should be suitably strengthened so as to cope up with additional responsibility that would accrue consequent upon the intensive health education activities at various levels.

Health Education Bureaux in the States/UTs should work in close collaboration with the AIR/TV/Field Publicity and other I & B Ministry Units and assist in organizing educational programme on health and family welfare to do this work. SHEBs should be allotted adequate funds in the Health Budget for media activities including the purchase of films on health subjects.

The Group felt that health cannot be isolated from other aspects of development of the country. All the health programmes involving different workers of various departments such as agriculture, development, cooperation, education, etc., should have tangible component of health education.

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## REPORT OF GROUP IV

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*Subject* : School Health Education.

The Group consisted of the following :

1. Dr. B.B. Ganguly	<i>Chairman</i>
2. Sh. S.D. Yadav	<i>Rapporteur</i>
3. Dr. J.S. Tong	<i>Member</i>
4. Dr. (Smt.) S. Kar	..
5. Dr. V. Palenivelu	..
6. Smt. Indira Saxena	..
7. Sh. P.C. Mahapatra	..
8. Sh. H.L. Chaturvedi	..
9. Sh. J.S. Manjul	<i>Resource Person</i>
10. Dr. S. Abdul Kareem	..
11. Smt. C.K. Mann	..

The Group agreed to the terms of reference provided by the CHEB but felt that in order to accommodate the proposed area (primary to college, formal and non-formal), it would have been better to rename the group as Students Health Education.

According to the Group, keeping in view the contemporary development in the conceptual level of student health education, health should not be considered only as a discipline or specialized area of knowledge, but as a part of life, a component of the environment which is constantly interacting with the other components of environment like hunger, poverty, over population, poor production of resources, pollution and exploitation. Like other components, health is not static but a dynamic one.

The Group observed that from the instructional materials developed at National and State levels, a trend of growth is noted in the area of student health education. All these efforts are on the basis of this realization that "health education is important". The Group considered the present state of student health education specially from the point of view of curriculum, teacher training, teaching

aids, etc., and felt that there exists scope for further improvement. The programmes for such improvement are essential because majority of our future population in 2000 A.D. are now in school or college going age-group.

The Group discussed the immediate need for strengthening student health education. The different aspects of improving student health services and betterment of health conditions in the educational institutions were specially considered. The Group felt that there exists scope for involving other persons and agencies specially all systems of medicines, retired persons and private practitioners and Medical Colleges who have so far been not utilized. The mobilization of community resources and involvement of people occupied major part in the thinking of the Group.

The need of knowledgeable and committed functionaries was repeatedly expressed by the Group. Thus, need specially of effective teachers, is thought to be important because the teachers will not only teach health concepts but will play an effective role in detecting and screening the students having health problems. The role of teachers as coordinator of different efforts for health promotion of students from community and home were discussed. The different aspects of teachers training (pre-service, inservice, continuing education) were discussed in detail and various issues were considered.

The Group discussed about the question of making health education need based and meaningful. It was felt that for effective health education it is necessary to properly identify the "System" in the environment where health is an important part.

The question of designing and development of teaching aids were discussed in detail. It was felt that teaching aids and materials should not be considered only as audio-visual items. On the contrary, all kinds of innovations are needed to help the teachers to provide better learning experience to the child.

The Group felt that research-based findings in the area of health education are insignificant. Such studies, are needed to be undertaken by university departments which have potential for such research as Education, Home Science, Social Work, Science and Medicine, etc.

After discussing about formal education, the Group discussed in length about the scope of health education in colleges and universities. Various efforts undertaken at the non-formal level have also been considered and the issues and strategies for this level have been discussed.

I. Considering the fact that a lot of health education input has already been made in the areas of formal and non-formal education and feeling the need to further strengthen health education in this Sector, it is recommended that

- a) An indepth study may be undertaken to ascertain the present position against what ought to have been done to determine gaps pertaining to implementation of health education for each level of education from pre-primary to college

level including Teacher. Training in respect of (i) health education concepts, (ii) methods, and media (instructional materials), (iii) objectives based evaluation (iv) teacher preparation, and (v) curriculum approach. This task may be undertaken jointly by the CHEB and NCERT involving experts from SHEBs, SCERTs, RCES and other key institutions.

- b) 'On the basis of the findings of the study and contemporary trends in the fields of health, health education, and school health education an *'Approach Paper' on Student Health Education* be developed jointly by the CHEB and the NCERT to provide a frame-work for planning, implementation and evaluation of health education at all leaves of education and in the field of non-formal education.
- c) 'Workshops/conferences/business meetings may be organized involving experts from State Education Departments, State Boards of Education, University, Faculties of Education, Adult Education, National Service Scheme to discuss the Approach Paper and find ways and means to implement health education on the lines of this paper.

II. Considering the fact that effectiveness of School Health Education Programme is affected due to the lack of proper set-up and feeling the need for inter-disciplinary cooperation and collaboration for strengthening health education in programmes of formal and non-formal education, it is recommended that

- a) School Health Education Division of the CHEB be named as Student Health Education Division to cover programmes from pre-primary to university levels. It should also be strengthened in view of increased demand for strengthening of health education at pre-primary and college/university levels.
- b) A *Student Health Education Unit* may be set up under a programme advisor in the Ministry of Education to promote and provide direction to the health education component of programmes of Formal and Non-formal education in the country, and similar cell may be set up in the NCERT to work hand in hand with Student Health Education Division of the CHEB.
- c) Student Health Education Units in the State Health Education Bureaux be strengthened on the pattern of CHEB and new units be set up in SCERTs on the pattern of the unit to be set up in the NCERT.
- d) Curriculum-Labs-cum-Resource centres should be set up at National and State levels and in the universities to facilitate research and studies in the field of methods and media, and production of instructional material for health education in formal and non-formal programmes of education.
- e) National Council of Teacher Education should take necessary measures for improving facilities for teacher preparation in health education.
  - i) Steps should immediately be taken up to upgrade and improve the quality of student health education component of pre-service and in-service

**training programmes in health education. Specialization in student health education be introduced for teachers and method masters in Diploma in Health Education (DHE) programmes being provided by Universities of Delhi, Madurai and West Bengal, at CHEB, Rural Institute of Health & Family Welfare, Gandhigram, and All-India Institute of Hygiene and Public Health, Calcutta.**

- ii) Special degree courses should be introduced in health education through the faculty of education in the universities.**
- iii) Health education component of teacher training programme in the universities and State Departments of Education be reviewed and modified to suit the needs of teachers in secondary and elementary schools. To begin with, these courses should be content-cum-methodology courses as there are no degree courses in health education available in the universities at present.**
- iv) Facilities for inservice training of teachers be provided with joint collaboration of SHEBs and SCERTs in the States.**

**III. Considering the fact that sick children are not able to benefit from educational programmes and also that adequate facilities are not available in the country for health appraisal of school children, it is recommended that**

**'Provision should be made to design a functional and operational system of health services to students with effective follow-up and supportive health education. Efforts should be made to seek collaboration from all systems of medicine practised in the country, voluntary organizations interested to work in this field, medical colleges, and Government and private hospitals, dispensaries, clinics, etc. Department of education should be actively involved in the monitoring of the programme'.**

**IV. Considering the fact that only a need based health education programme can be successful it is necessary to undertake community diagnosis for planning a meaningful health education programme with active involvement of community, home and school, it is recommended that**

- a) Pilot Projects may be designed and undertaken jointly by State Health and Education Departments (SHEBs and SCERTs) in consultation with CHEB and NCERT to evolve models for effective coordination and collaboration between home-school-community for health promotion of school children. Departments of Adult Education, National Service Scheme and colleges/universities should also be associated with these projects.**
- b) Junior and senior fellowships be provided to the universities on the pattern of UGC to promote inter-disciplinary research in health education at Post-graduate level leading to award of Ph.D. Degree in health related problems in such fields as Home Science, Education, Social Work, Medicine, etc.**



V. Considering the fact that large number of illiterate and literate people in the country are ignorant about simple rules of health and their behaviour is influenced by health related superstitions, unfounded beliefs, fads and misunderstandings, it is recommended that

'Essay competitions, painting competitions, programme of seminar readings on health related themes, WHO day theme, or any other important health area may be organized for non-formal groups of education (NSS and Adult Education) and for professional groups to motivate them to develop habits of reading technical material to update their knowledge.'

VI. Accepting the fact that details cannot be worked out in a short period of time and realizing that many details are to be worked out utilizing inter-disciplinary expertise related to various aspects of health education programmes it is recommended that

'Working groups should be constituted for discussing explicit and implicit details with regard to implementation of each recommendation made during this conference and thereafter for following up action as decided by the groups.'

# **APPENDICES**

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## SUMMARY & CONCLUSIONS OF STATUS STUDY REPORT

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The importance of health education in achieving public health goals of India has been reiterated many times in official health surveys, in documents of the Planning Commission, and in resolutions of the Central Council of Health, a high power policy making body of the Central and State Health Ministers, with the Union Health Minister as the Chairman.

The Central Health Education Bureau (CHEB) came into being in 1956 in the Directorate General of Health Services (DGHS) with a view to developing health education speciality on scientific lines. Before the inception of the Bureau, a Health Publicity Division in the Directorate General of Health Services was putting out educational/publicity materials on different health subjects on ad-hoc basis and was organizing film-shows in and around Delhi.

The CHEB in 1959 prepared a scheme for the establishment of Health Education Bureaux in the State Health Directorates. Financial assistance was offered to the States by way of 50 per cent recurring and 100 per cent non-recurring grants during the Second Plan period, but this assistance was discontinued after the Fourth Plan. Consequently, there has not been a uniform development of Health Education Bureaux in the country. However, some States have done extremely well in establishing Health Education Bureaux but a number of them have set up a nucleus only.

It is now 23 years since the establishment of CHEB. A lot of work has been done in different aspects of health education, namely, training, research, school health, communication support, etc.

The CHEB took up a study in 1979 to review the status of health education service in the country. The study, among other things, covered assessing the present position of health education in India, especially in the light of its important place in the new health policy of the Government, analysing the reasons for lopsided growth of the programme in States and Union Territories. It also covered a review of health education content in the syllabi of various categories of health personnel

such as medical, nursing and paramedical personnel, teachers, etc., and make suitable recommendations and indicate research needs in health education.

Given below are the general and specific objectives of the study :

### **General Objectives**

To study the status of health education in India.

### **Specific Objectives**

1. To find out manpower in health education training, research and education activities;
2. To find out the component of health education in the training curriculum of health and non-health workers at various levels;
3. To find out health education research activities;
4. To find out problems and impediments in carrying out health education activities; and
5. To suggest a strategy of plan for development of health education.

The study covered all States and Union Territories, as well as training and service institutions working in both health and non-health fields. Nearly 1700 organizations were covered for the study.

A set of 15 questionnaires was prepared which sought information on various aspects of health education activities. Questions were both open and closed, depending on the nature of the information to be secured. In total, 2628 questionnaires were sent out of which 752, or roughly 28.6 per cent were received back with relevant data. Response from the hospitals was the highest, being 72.3 per cent, followed by the State Health Education Bureaux (72 per cent), while the lowest feedback was from district health education units, being 16.7 per cent.

The summary and conclusions of the report are given below.

### **State Health Education Bureaux**

The SHEBs are found to be of three major types/status. These are (1) Bureaux, (2) Units and (3) Cell. The Bureau-status SHEB refers to one which is adequately equipped with all or most of the technical divisions as prescribed, the Unit-status SHEB is one which has few technical divisions, and the Cell-status SHEB is one which has no technical division but, only existing staff carry out all the activities. All the 18 SHEBs have been established in the span of nearly 20 years, *i.e.*, 1959 to 1979. All the four SHEBs have media and administrative sections, research does not exist in most of the SHEBs, in other words, it is greatly neglected. There are no uniform pay scales for the same categories of the officials particularly artist, projectionist, public health nurses, technical officers and Assistant Director of Health Services, etc. The number of other technical staff too greatly differs from Bureau to Bureau. Regarding the educational status of the staff, half of the technical staff

are graduates and above, including medical personnel. About the budget allocation for the years 1977-78 and 1978-79, the allocation to the health sector as such does not appear to be unsatisfactory, but the share given to health education is certainly very much low. Of the 10 Bureau-status SHEBs, only two SHEBs, allocated a budget between 14 to 20 lakh, five are between one to eight lakh and three are between Rs. 42,000 to 94,000. Among these, only three SHEBs have allocated budget for health education between 2-4 per cent in the total budget. About the Unit-status SHEBs, the budget allocated is found to be very low for the year 1977-78. However, there is a slight increase in the budget for the year 1978-79 excepting one SHEB. Almost similar is the case with the Cell-status SHEBs. Most of the SHEBs actively participate in the adult education programmes, CHV training and National Health Programmes. The method used in health education activities include lecture, supply of educational material, participation in seminars and workshops, provision of guidelines for the training and conduct of health education campaign. When compared with other programme, only Leprosy Control Programme seems to have more health educators. State Health Education Bureaux have huge distribution list to which health education material are despatched periodically. The institutions to which the health education material are distributed, include all medical and public health institutions, municipal corporations, municipal committees, hospitals, schools, colleges, primary health centres, voluntary organizations. Health Education material production too ranges from 1,000 copies to two lakh copies, the material being posters and handbills, folders, pamphlets, booklets, etc. The problems faced by the SHEBs are mainly, lack of finance, lack of transport facilities, shortage of trained personnel, administrative hurdles, etc. The suggestions made by the SHEBs to overcome these problems are more staff to be trained, provision of more fund, improvement in the physical facilities, better co-ordination with various departments and institutes.

### **District Health Education Units**

District Health Education Units are next to SHEBs at the district level to carry out health education activities in the country. With a view to know health education activities at the district level *vis-a-vis* role of district health education units, separate questionnaire was sent to 257 district health education units of which only 43 (16.7 per cent) replied which indicates the poor response from these organizations. Thus the analysis is based on data from 43 district health education units.

A large number of district health education units are conducting their health education activities through film shows with the staff available for the purpose. Very few district units are having health educators and officers with the result that health education activities through directly meeting with people and educating them do not prove effective. The reasons for this are that most of the units do not have trained personnel; and where they are trained, the staff do not enthusiastically participate in these activities due to the lack of promotional avenues. Secondly, the staff is involved mostly in Family Planning Programme as a result of which the work experience of the staff is restricted to a few programmes. In other words, health programmes get less emphasis. Thirdly, a large number of units do not have adequate finance to conduct health education activities in spite of having separate budget.

Fourthly, physical facilities are very poorly provided. Due to poor transport facilities, these units are unable to cover the total area under their geographical jurisdiction. Fifthly, although very large number of health education units are receiving guidance in planning and implementation from either Chief Medical Officer, Medical Officers, the coordination of these activities are done at the PHC level by the MOs. Thus, the coordination at lower level is more effective than at the district level. Such a coordination can be improved very much at the district level by strengthening the machinery and giving training and orientation to the staff as well as by enhancing budget and providing better physical facilities to these units.

### **Primary Health Centres**

Primary Health Centre is a service institute as well as a training institute. Information related to training and health education activities being conducted by the PHC was received from 53 out of 257 PHCs. The PHCs are found to be following prescribed curriculum of training. Individual talks and group meetings are found to be the major health education activities of most of the PHCs. Activities such as film shows and exhibitions are done on a lesser scale. The health education material required by the PHC in most of the cases is procured from the district health organization and other government agencies. The staff of the PHCs have undergone mainly three kinds of training courses but most of them have undergone either the certificate course in health education, in-service training courses and orientation courses. More PHCs have coordinated their activities through block level officials. The problems that are faced by the PHC in conducting health education are mainly related to funds which is also reflected under the poor physical facilities or training facilities. The primary health centres have pleaded for more funds and supply of mass media material.

### **Nursing Schools and Colleges**

Nursing schools and colleges are the training institutions which can contribute a lot for development of health education. These institutions are directly involved in the health programmes. Through this training these institutions prepare them for delivery of health services. A number of Government and voluntary agencies are imparting training in nursing. For collecting relevant information from such nursing schools and colleges, the questionnaire was sent to 255 out of which 126 or 49.4 per cent responded.

Nursing schools and colleges in the country conduct courses between two to four years, and a very few institutions offer one year course. The strength of the students varies from a minimum of 20 to maximum 80.

Health education is not taught as a separate subject in majority of the nursing schools and colleges. In the institutions teaching health education, the time allotted for this subject ranges between one and 91 hours. Students in these institutions are also given practical experience in different areas of the subject.

The nursing schools and colleges do not seem to be concerned with the inclusion of health education in the curriculum. Many institutions prefer to integrate this subject with other papers rather than teaching it separately. Most of the schools (73.7 per cent) have integrated health education with community health

nursing/public health nursing. Those which have integrated with maternal and child nursing are 44.2 per cent and with medical and surgical nursing, 38.4 per cent. Even in the institutions where it is taught, no separate question is asked in the examination. The important method of teaching health education is found to be lecture and class-room teaching. Mainly printed materials, audio-visual aids and indigenous aids are used in teaching. Sometimes, students also use aids and equipment prepared by themselves. Faculty trained in health education is found in less than fifty per cent of the institutions. Almost all institutions follow the syllabus prescribed by Indian Nursing Council.

In the opinion of majority of nursing schools and colleges, lack of adequate physical facilities and insufficient training to teachers are the major difficulties they are facing. An improvement in these spheres could strengthen the health education component.

### **ANM Schools**

ANM Schools are other training institutions conducting training on the pattern of nursing schools and colleges. The information was collected through 67 schools. The response from these institutions was 40.8 per cent.

Analysis of data for the ANM Schools reveals that the prescribed curriculum is followed by almost all the schools but the number of batches they are admitting every year is not uniform. The duration of the course for ANM is of two years as prescribed but there also appears to be some variation. Teaching health education as a separate subject has been accepted in most of the schools but some have reservations to teach health education as a separate subject, and therefore, they have integrated it with number of other subjects, among which major are, personal and community health, medical and surgical nursing. The major field areas for giving practical experience to their students is hospital in which most of the schools (68.7 per cent) give their students experience in health talks. But whenever they are exposed to the field, most of them prefer health education work in the community, thus showing their interest in health education outside the hospital situation. Regarding methods used in health education teaching, although they vary from one situation to another, the printed material and other channels of mass media are the two major methods occupying a significant place. Lecture methods including discussions and dialogues in the seminars and conferences are found to be more favourable in teaching. If the suggestions for improving health education component in the curriculum against the background of the methods used for instruction and teaching are taken, most of the schools suggest increased supply of printed material on this.

### **MPW/CHV Training**

Relevant information was available only from 49 training centres out of 257 to whom the questionnaire was sent. Although health education component is found in the training programmes conducted by the PHCs particularly for MPW/CHV, it is not sufficient to equip the health workers to deliver health education services effectively. Thus, the need that is ultimately felt is to increase the component of

health education in the training course offered to these categories of workers. It is quite disheartening to observe that the trainees could not acquire sufficient knowledge and skill even after undergoing such a training. However, it is difficult to attribute the fault to any one of them either, trainees or trainers. Suggestions for strengthening health education activities include increased availability of funds and better physical facilities

### **Training of Extension Educators**

Extension educators are generally working in the non-health field at the block and village level. These functionaries work as an agent of change in health behaviour in the community if they are given some basic knowledge in health education. In order to find out the quantum of health education in the training curriculum, 83 training centres were covered of which about 41 per cent responded. Notably six categories of extension workers are trained by the training institutions. The duration of the course ranges from less than one week to two years, depending upon nature and requirement of the trainees.

A variety of subjects are taught. It is seen that a majority of institutions teach health education, but the time allotted for teaching theory as well as practical and field work in these institutions is very less. The theory part of the Extension Education is given more time than the practical and field work. Few institutions teach other subjects related to agriculture; and the hours devoted for theory, practical and field work are more to subjects related to health.

Availability of equipment and better facilities are the major requirement to strengthen health education component in the training. This is suggested by three-fourth of the institutions. Again less than half of them feel that adequate funds and effective co-ordination would strengthen components of health education in the training extension workers.

### **Health Education Research**

In order to assess the activities related to health education research in the country, 375 questionnaires were addressed to different organizations, out of which 17.6 per cent provided us the information on the areas of research, manpower, publications, problems and suggestions, etc.

The analysis of the information of health education research shows that more than 50 per cent of the organizations have not undertaken health education research during reference period—January 1977 to December 1978. It is seen from the earlier discussions that most of the organizations belong to government sector and as such those which have not undertaken or been undertaking investigations are only from government sector. This shows a discouraging picture of the interest that the organizations have in health education research. It is again significant to note that 95.4 per cent of the organizations do not have separate budget to carry out investigations in different fields of health. It shows the plight of



health education research in the organizations from government sector. The organizations that have undertaken studies have conducted more studies in health behaviour and practices and educational methods and aids. Few studies were found to be undertaken in the educational approach and process of behavioural change in the community. The subjects that are covered in the investigations indicate that more studies are related to maternal and child health followed by family planning and population education. The studies in nutrition programme and health behaviour are very few. Another important area in which health education research can be done, is evaluation of training programmes, communication and health schemes. However, these three areas have not received due attention from the organizations. Dissemination of the findings emerged out of the analysis assumes important place in awakening the interest of the community, policy makers, and health experts. Thus the need of publishing such studies arises. The status of publication of these studies in these organizations is not discouraging, in the sense that 66.6 per cent of the studies were published by the organizations. We find that 66.6 per cent of the published studies are mainly on family planning and population education. It is found that although more studies are conducted in material and child health care, only one-fourth of these studies seem to have been published.

Regarding health education research manpower, analysis gives a very gloomy picture. Although majority of the organizations (91.6 per cent) have technical staff to carry out this specific activity, the research personnel as such are found in very few organizations (8 out of 33). The staff engaged in other major activities such as training, health education, etc., do little justice to research activities. No organization has a scheme of sponsoring research in health education.

## **Hospitals**

Hospital is a service institution rather than training institution. It directly deals with public and, therefore, health education activities if carried out by this institution are more effective to educate a large population. A response to the questionnaire from the hospitals was the highest (73.3 per cent).

There are more teaching hospitals at district level than at the State hospital. The hospitals have observed three major preventable health problems—*infectious diseases, nutritional disorders and gastrointestinal*. Sexually Transmitted Diseases are also on the increasing side. To impart knowledge about these preventable diseases hospitals are playing an important role. The means of educating the public on health is mostly individual talks. It seems that the person to person teaching on health education is very effective at the hospitals and in such activities the doctors and health educators are taking the lead. Although audio-visual media and exhibition material on health education is also used, the individual talks are more effective than any other.

Contrary to this, while the health educators of hospitals go for community work, display of media seems to be more effective than person to person talks or group meetings. From this it can be said that people whenever they fall sick, they

listen patiently to individual talks but the same method is not effective during the community work programmes, because people prefer to watch than to listen.

It is proved that trained health educators are very much effective if they are available at the hospitals but only a little more than half of the hospitals are having trained personnel which shows the inability of the hospitals in conducting health education activities. Wherever these trained health educators and trained doctors are available in the hospitals, they prove to be the best coordinators of the health education activities. It can be concluded from the suggestions given by the hospitals that creating separate health education cell and providing adequately trained personnel in health are very much required. Thus the health education activities can be widened through hospitals.

### **Institutions of Education**

Majority of the institutions of education have text books on health education. No specific time for teaching health education is mentioned by the institutions, due to which it is difficult to assess actual teaching of the subject. Libraries of these institutions are much poor in respect of health education material. The institutions do not have trained staff in health education. As a result they find it difficult to organize health education activities in a proper direction.

### **Teacher Training Institutions**

It is a matter of concern to see that the efforts that are put by the educational institutions in health education for training their teachers either for elementary classes or for secondary classes are poor. Excepting one, no institution has been teaching health education as a separate subject. Moreover, the time devoted for its teaching is so low that no justice could be done to this subject. There is no provision made in any of the institutions to develop special skill in health education among the teachers. Whatever teaching aids used are mostly found in the institutions training teachers for secondary classes. Evaluation of training is done by simple observation and by holding written test. No community work is undertaken by these institutions barring one. Since most of the institutions have not included health education as a separate subject in their curriculum for training teachers no separate question is ever put in the examination.

### **Adult Education Programmes**

Regarding adult education programmes, both medical and non-medical personnel have been responsible for training instructors, however, the training faculty too, in most of the cases are untrained. Health education teaching in the voluntary organizations is of short duration and that too in a few organizations. Voluntary organizations working in different fields are doing more work in health education compared to other three institutions, namely, Institutions of Education, Teacher Training Institutions and Adult Education Programmes. Almost all organizations conduct health education activities along with their routine activities. Most of them organize health education programme through film shows, exhibitions and display of posters

Most of them (73.8 per cent) seek assistance for conducting health education activities from other agencies, such as CHEB, SHEBs, medical colleges and hospitals. It is paradoxical that they are conducting regularly the health education activities but have no trained staff in health education. Their major and foremost problems are untrained personnel, inadequate funds and non-availability of health education material. They stressed serious concern over non-coordination between them and Government agencies for promotion of health education activities.

The following are the conclusions drawn from the study :

**(A) State Health Education Bureau x**

In most of the SHEBs in the States and Union-territories there is no adequate staff to carry out health education activities and even the staff available are not trained in health education.

The staff in the SHEBs even with similar post are placed in different scales, in other words there is a vast disparity in pay scales in the similar post. Although the health education budget is apparently satisfactory, the health education budget in the total health budget in most of the SHEBs is very much low which hampers health education activities. A general feeling of the health educators at the SHEB is that the low weightage is given to health education by the administration. Most of the SHEBs felt that there is a great need for health education research.

**(B) District Health Education Units**

District Health Education Units do not have sufficient trained health educators. The promotional avenues for the staff are very meagre and it dampens enthusiasm of the workers in the jobs assigned to them. District health education units face lack of financial support, resulting in the poor management of physical facilities, *vis-a-vis*, ineffective organization of activities. The health educators are mostly involved in the activities related to family planning programmes rather than to health and health education.

**(C) Primary Health Centres**

At the level of Primary Health Centres, individual talks and group meeting are the major health activities organized while at the Sub-Centre level, group meetings and distribution of the health education material are done. There is a close coordination between the Primary Health Centre and block level officials and this needs to be strengthened. The major problems faced by the Primary Health Centres are lack of physical facilities and shortage of funds.

**(D) Nursing Schools and Colleges**

Most of the Nursing Schools and Colleges follow the curriculum prescribed by the Indian Nursing Council of India but health education does not fall as a separate subject in the curriculum in most of the schools (85 per cent). The teaching hours allotted to health education are very less in the total course as compared to

other subjects. Very few schools (23.4 per cent) take their students in rural areas for practical experience. Most of these schools are providing field experience to the students in midwifery and school health but this is confined to urban areas only. Health education has been integrated mainly with community health nursing, public health nursing and secondly with midwifery and nursing. More than half of the schools have no question on health education in the examination papers. The students in most of the schools prepare one or the other technical material on health education. About half of the schools have no trained staff. As regards the material such as books and material on health education, most of the schools have been working independently without any assistance from other agencies.

#### **(E) Auxiliary Nursing Midwifery**

All the ANM schools are found to be following a prescribed syllabus. However, health education is not taught as a separate subject in more than three-fourth of the schools. The duration of training is of two years in a large number of ANM schools. Health education is integrated mainly with community health and medical and surgical nursing. The students are giving experience in the health education talks in school situation by most of the schools. The most favoured aids for health education teaching are printed material and mass media; but for instructions, lecture method is more prominent. The major suggestion of the schools was for supply of printed material and other mass media material.

#### **(F) Training Programme for M.P. Workers/Community Health Volunteers**

The primary health centres have not successfully involved community in health programmes. In the majority of the PHCs (84.5 per cent) the workers have gained knowledge and skills to some extent.

#### **(G) Sanitary Inspector Training Institutions**

Health education forms as a separate subject in the training curricula in half of the institutions. Majority of the institutions have included question on health education in the examination papers. The libraries of these institutions are well-equipped with health education books.

#### **(H) Research in Health Education**

Little more than half of the organizations have undertaken research in health education during the reference period, *i.e.*, January 1977 to December 1978. The studies conducted are more on health behaviour and practices (84.2 per cent). Most of the organizations (62.4 per cent) published studies on family planning and population education. As regards the health education manpower only 24.2 per cent organizations have little staff. Pay scales of various personnel carrying the same designation and probably the same activities vary to a great extent from State to State. The major problems faced in conducting health education research are non-availability of research manpower and shortage of funds. A sizable number of organizations (34.3 per cent) have suggested to undertake studies in health education programmes and (31.2 per cent) suggested studies in health behaviour of the people.

## **(I) Hospitals**

More preventable health problems in the hospital are infectious diseases, nutritional and gastro-intestinal ailments. Sexually Transmitted Diseases too are on the increase. Doctors and health educators take more lead in conducting health education activities in hospital situation. More health education activities are conducted in the hospitals but less in the community. Doctors are not taking the lead in community work outside the hospital situation. Peripheral level workers are found to be doing more health education activities in the community. As regards the training status of the staff in the hospital, in the (58 per cent) of the hospitals, the staff are found to be trained in health education. Most of the social workers in the hospitals have received orientation in the field of family planning. In most of the cases, health educators are considered the best suitable persons to organize health education activities in the hospitals.

## **(J) Status of Health Educators**

A great majority of health educators (85 per cent) are trained in health education and 81.3 per cent of the health educators have undergone one year training. A large number of health educators have put in more than a decade in the service. There exists enormous diversity of pay scales for the health educators carrying the same designation. Most of the health educators have no promotional avenues open to them in their organizations. The Deputy District Health Educators are the worst affected. The supervisors of health educators are trained while it is not the same in the case of Health Education Officers, State/District Health Educators and Deputy/District Health Educators. Most of the health educators are working under the supervision of the Principals of the RHFWTCs.

## **(K) Health Education in Generally Educational Institutions**

Majority of the institutions have text-books on health education. But libraries of most of the institutions are not adequately equipped with health education books and materials. None of the institutions have teachers trained in health education.

## **(L) Teacher-Training Institutions**

Health education is not taught as a separate subject in most of the institutions. Very few institutions provide opportunities to the training teachers to develop scheme and majority of institutions (64 per cent) do not provide any practical training in health education. The students in almost all institutions excepting one are not supposed to undertake community health project.

## **(M) Adult Education Programmes by State Directorate/State Department of Social Welfare**

Majority of the institutions are found to be conducting health education activities. In these institutions, mostly medical personnel are engaged in training the instructor in health education. As regards the supply of A.V. Aids, the adult education programmes are getting this educational material from the Government agencies.

## **(N) Voluntary Organizations**

Almost all voluntary organizations carry out health education activities along with their routine work. These activities are mostly carried out by untrained staff. Considerable amount of health education work is being done by these organizations. These are individual, group and mass meetings, film shows, exhibitions, demonstrations, etc.

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## EVALUATION OF THE CONFERENCE

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A quick evaluation of the participants' reactions about the Conference, the arrangements and other related aspects, was carried out by a Research Team of the Central Health Education Bureau. A four-member participants Evaluation Committee was also associated with this study. Details of its findings are given here :

### Members of the Evaluation Committee

Shri P. Shanmugam  
Dr. M.C. Verma  
Shri S.P. Nigam  
Dr. S. Abdul Kareem (Chairman)

### C.H.E.B. Members

1. Dr. A.B. Hiramani
2. Smt. Usha Shrivastava

The evaluation consisted of eliciting reactions of the participants including resource persons. A structured questionnaire was administered to 31 participants on the last day of the Conference.

The questions were set to obtain reactions on salient features of the Conference. These were broadly on :

(1) Accomplishment of Conference's objectives, (2) opportunity to participate, (3) appropriateness of work schedule, (4) relevance of background material, (5) utility of resource persons and guest speakers, (6) availability of secretarial assistance and accommodation for Conference activities, (7) duration of Conference, (8) usefulness of exhibition, and (9) suggestions for improvement of such conferences. Suggestions were also sought on five major areas, viz., frequency and venue of Conference, physical facilities, and follow-up action.

### Findings

Most of the participants (23 out of 31) were of the view that the Conference objectives were partially accomplished. A little more than half of the participants reported the Conference met their expectations to some extent only. A little less than one-third admitted that their expectations were met to a great extent.

More than half (18 out of 31) had full opportunity to participate in the Conference while 10 participants were able to participate only partially.

Regarding the work schedule of the Conference, only 15 participants said it was appropriate, whereas, 12 said it was somewhat appropriate.

Almost all the participants except two who responded to the questionnaires found the background material relevant. Eighteen participants found the resource persons useful and 11 found them fairly useful. Majority of the participants said specialists and guest speakers were quite useful and another one-fifth said they were fairly useful. The secretarial assistance was reported to be quite adequate by nearly two-thirds of the participants. But for the two who did not reply, the rest found the assistance fairly adequate. In the opinion of 23 participants, accommodation for the plenary session was adequate while only 13 participants found the accommodation for group work adequate. Three participants found that both for plenary and group work the accommodation was inadequate.

Team work was said to be good and fair by 19 and 10 participants respectively. Only two said it was poor. Attendance at Conference was good as observed by two-third of the participants. Eight participants felt the attendance was fair.

About 60 per cent of the participants felt that there was full and partial accomplishment of task set before by the groups. More than two-third of the participants observed that duration of the Conference was sufficient. The rest were almost equally divided in their views about the duration being fairly sufficient and insufficient.

On the question of functioning of the Conference Committee, only 26 replied. Fourteen and 12 participants respectively were of the opinion that this Committee functioned satisfactorily and somewhat satisfactorily. More than half of the participants found the exhibition put up by the CHEB useful to some extent and little less than half felt it was useful to a great extent.

As regards social activities, most of them were disappointed as there were no social activities conducted during the Conference.

The participants were asked to give suggestions for improvement for such conferences, in terms of frequency, its venue, follow-up action and physical facilities. Majority of the participants (17 out of 27) wanted the Conference to be held in the State capital instead of at New Delhi. Thirteen out of 27 participants wanted to have such Conferences once a year. Three each wanted it to be held every alternative and once in three years respectively. Physical facilities provided by the organizers were found to be somewhat unsatisfactory. One-fifth of those who replied wanted the CHEB to arrange the boarding and lodging for the participants. Rigorous follow-up action on the Conference recommendations by the CHEB was suggested by 13 participants. Feedback by the districts and States to the Centre was suggested by three participants while inter-State visits/study tours were suggested by two participants.

The other suggestions included more regional level Conferences, cutting short length of plenary sessions, advance planning, setting objectives clearly, more time for discussions, more involvement of voluntary agencies, careful selection of background papers and their timely and advance despatch to participants.

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# **LIST OF PARTICIPANTS**

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1. Acharyya, Dr. C.                                 Director, Health Services  
  Tripura
2. Annakuthy, Smt. Roche                         Organising Secretary  
  Hind Kusht Nivaran Sangh  
  Delhi
3. Biswas, Dr. N N.                                 Dy. Director (Trg.)  
  Central Health Education Bureau  
  New Delhi
4. Bawa, Shri P.S.                                 Research Officer  
  Central Health Education Bureau  
  New Delhi
5. Bhatia, Dr. J.R.                                 Professor  
  National Institute of Health and  
  Family Welfare  
  New Delhi
6. Bhasin, Shri T.R.                                 Publicity Assistant  
  Health Education Cell  
  Municipal Corporation of Delhi  
  Delhi
7. Bali, Dr. R.M.                                 Dy. Director of Health Services  
  Himachal Pradesh
8. Bhandula, Shri B.R.                             State Health Education Officer  
  Himachal Pradesh
9. Bagley, Dr. V.M.                                 D.A.D.G. (PST)  
  Central Health Education Bureau  
  New Delhi



10. Chhabra, Shri R.K. Secretary  
University Grants Commission  
New Delhi
11. Chauhan, Dr. J.S. Asstt. Prof of Health Education  
All-India Instt. of Hygiene and  
Public Health  
Calcutta
12. Chaudhuri, Shri Narayan S.M.E.I.O.  
West Bengal
13. Chaturvedi, Shri Hira Lal Health Education Officer  
Madhya Pradesh
14. Chakraborty, Dr. A.K. D.A.D.G. (M&T)  
Central Health Education Bureau  
New Delhi
15. Chandola, Shri B.D. Health Education Officer  
Central Health Education Bureau  
New Delhi
16. Dutta, Dr. B.M. DADG (PH)  
Central Health Education Bureau  
New Delhi
17. Dutta, Dr. G.D. Asstt. Director of Health Services  
Punjab
18. Grover, Dr. Harish Hony. Jt. Secy.  
Indian Medical Association  
New Delhi
19. Gulati, Dr. P.V. Prof. of P.S.M.  
Lady Hardinge Medical College  
New Delhi
20. Gandhi, Shri C.C. T.O. (Media)  
State Health Education Bureau  
Gujarat
21. Ghosal, Dr. B.C. Director  
Central Health Education Bureau  
New Delhi
22. Ganguly, Dr. B.B. Professor  
National Council of Educational  
Research and Training  
New Delhi
23. Hassan, Dr. S.H. W.H.O. Consultant  
New Delhi

24. Hiramani, Dr. A.B. Dy. Director (Research)  
Central Health Education Bureau  
New Delhi
25. Kakar, Shri V.N. Chief (Media)  
Deptt. of Family Welfare  
New Delhi
26. Kar, Dr. (Smt.) S. Asstt. Director of Health Services  
(School Health & H. Edu.)  
West Bengal
27. Kareem, Dr. S. Abdul Jt. Dir. (HE&SH)  
Karnataka
28. Khosla, Shri P.N. Health Education Technician Gr. I  
Central Health Education Bureau  
New Delhi
29. Lakshminarayan, Shri D. Asstt. Editor (Radio & TV)  
Central Health Education Bureau  
New Delhi
30. Mehta, Dr. S.P. Prof. of P.S.M.  
JIPMER  
Pondicherry
31. Murry, Dr. L.M. Jt. Director of Health Services  
Nagaland
32. Mann, Smt. C.K. Health Education Officer  
Central Health Education Bureau  
New Delhi
33. Manjul, Shri J.S. Dy. Director (SHE)  
Central Health Education Bureau  
New Delhi
34. Nawani, Dr. N.P. Director  
Ministry of Social Welfare  
New Delhi
35. Nigam, Sh. S.P. State M.E.I.O.  
Madhya Pradesh
36. Narain, Shri G. DADG (Exh.)  
Central Health Education Bureau  
New Delhi
37. Pandit, Smt. A. Programme Officer  
Deptt. of Family Welfare  
New Delhi

38. Pandit, Dr. (Kum.) S.A. DADG (HE)  
Central Health Education Bureau  
New Delhi
39. Philip, Dr. Lois Prof. of Health Education  
All-India Instt. of Hygiene &  
Public Health  
West Bengal
40. Parthasarathy, Shri T.K. Editor  
Central Health Education Bureau  
New Delhi
41. Palanivelu, Dr. V. Student Health Officer  
Pondicherry
42. Rao, Smt. Sumathy S. Health Education Training Officer  
Dte. of PH & Prev. Medicine  
Tamil Nadu
43. Ray, Kum. Sipra Dy. Director  
Doordarshan Kendra  
New Delhi
44. Sinha, Dr. N.K. Dy. Advisor (Health)  
Planning Commission  
New Delhi
45. Sehgal, Dr. P.N. Dy. Director  
National Instt. of Communicable Diseases  
New Delhi
46. Sanjar, Smt. Sarvat Producer, Health Programmes  
T.V. Centre  
New Delhi
47. Singh, Smt. Leila Staff Officer  
Indian Red Cross Society  
New Delhi
48. Singh, Dr. Harcharan Prof. of P.S.M.  
Govt. Medical College  
Patiala
49. Saxena, Shri G.G. Officer I/c Trg. & F.S.D.A  
Dte. of Health Services, Haryana.
50. Subbegowda, Shri H.B. Asstt. Deputy Director (H.E. & S.H.)  
Karnataka

51. **Shanmugam, Shri P.**  
Coordidator, D H.E. Course  
Gandhigram Instt. of Rural  
Health & Family Welfare  
Gandhigram
52. **Samson, Dr. Sojibai**  
Prof., P.S.M.  
Christian Medical College  
Vellore
53. **Selukar, Dr. S.K.**  
Asstt. Director of Health Services  
Maharashtra
54. **Sarmah, Shri R.N. Dev**  
Health Education Officer  
State Health Education Bureau  
Assam
55. **Sinha, Dr. K.S.**  
D.A.D.G (NM)  
Central Health Fducation Bureau  
New Delhi
56. **Sawhney, Shri R.S.**  
Health Education Officer  
Central Health Education Bureau  
New Delhi
57. **Saxena, Smt. I.**  
Health Education Officer  
Central Health Education Bureau  
New Delhi
58. **Tong, Dr. James**  
Executive Director  
The Voluntary Health Association  
of India  
New Delhi
59. **Tariang, Dr. (Kum.) J.**  
Asstt. Director of Health Services  
Meghalaya
60. **Varma, Dr. M.C.**  
State Health Education Officer  
Uttar Pradesh
61. **Vasudeva, Dr. Y.L.**  
Prof. P.S.M.  
Medical College  
Rohtak (Haryana)
62. **Yadav, Shri S.D.**  
Health Education Technician Gr. I  
Central Health Education Bureau  
New Delhi

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## LIST OF MEMBERS OF PLANNING GROUP

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- |     |  |                                      |
|-----|--|--------------------------------------|
| 1.  | Dr. B.C. Ghosal<br>Director<br>C.H.E.B.                  | <i>Chairman</i>                      |
| 2.  | Dr. N.N. Biswas<br>Dy. Dir. (Trg.)<br>C.H.E.B.           | <i>Member</i>                        |
| 3.  | Sh. J.S. Manjul<br>Dy. Director (SHE)<br>C.H.E.B.        | -do-                                 |
| 4.  | Dr. A.B. Hiramani<br>Dy. Director (Research)<br>C.H.E.B. | -do-                                 |
| 5.  | Sh. T.K. Parthasarathy<br>Editor<br>C.H.E.B.             | -do-                                 |
| 6.  | Dr. A.K. Chakraborty<br>D.A.D.G. (M&T)<br>C.H.E.B.       | -do-                                 |
| 7.  | Dr. K.S. Sinha<br>D.A.D.G (N.M.)<br>C.H.E.B.             | -do-                                 |
| 8.  | Sh. G. Narain<br>D.A.D.G.(Exh.)<br>C.H.E.B.              | -do-                                 |
| 9.  | Dr. (Kum.) S.A. Pandit<br>D.A.D.G. (HE)<br>C.H.E.B.      | <i>Co-Director of the Conference</i> |
| 10. | Smt. C.K. Mann<br>H.E.O. (T)<br>C.H.E.B.                 | <i>Co-ordinator</i>                  |

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## CONFERENCE PROGRAMME

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February 26, 1980	9.30 - 1030 hrs.	: Registration
	10.30 - 11.30 hrs.	<i>Inaugural Session</i>
		Invocation : College of Nursing, Welcome : Dr. B. Sankaran Director General of Health Services
		Purpose & Scope of the Conference : Dr. B.C. Ghosal Director, CHEB.
		Inaugural Address : Sh. N.R. Laskar Minister of State for Health and Family Welfare
		Remarks : Mr. D. A. W. Nugent Programme Coordinator (WHO)
		<i>Chairman</i> : Sh. Kripa Narain Secretary, Ministry of Health and Family Welfare
		Vote of Thanks : Dr. I. D. Bajaj Addl. Dir. General of Health Services
		National Anthem
	10.00 - 11.45 hrs.	: Inauguration of Exhibition by Health Minister
	11.45 - 12.00 hrs.	: Tea/Coffee
	12.00 - 13.00 hrs.	: Formation of Groups

	13.00 - 14.00 hrs.	: Lunch Break
	14.00 - 15.00 hrs.	: Presentation of Report & discussion : Dr. B. C. Ghosal <i>Chairman</i> : Sh. N.N. Vohra, Jt. Secy , Ministry of Health.
	15.00 - 15.15 hrs.	: Tea/Coffee Break
	15.15 - 16.00 hrs.	: Discussion on the Report.
	16.00 - 16.30 hrs.	: Group Formation ( <i>Contd.</i> ) 1. Health Education Specialist 2. Health Professionals 3. Community Health Education 4. School Health.
	16.30 - 17.00 hrs.	: Meeting of Committees 1. Steering Committee 2. Evaluation Committee 3. Editorial Committee.
February 27, 1980	9.30 - 10.00 hrs.	: <i>Plenary Session 1</i> Report of Working Committees
	10.00 - 11.30 hrs.	: Review of pre-service & in-service professional and non-professional training in health education in the country and scope for further modification—A Symposium-forum. 1. Dr. Harcharan Singh, Prof., P.S.M., Govt. Med. College Patiala. 2. Dr. Lois Philip, Prof. of Health Education, A.I.I.H. & P.H., Calcutta. 3. Dr. (Smt) S. Krishnan Principal, College of Nursing. 4. Dr. B.B. Ganguly, Prof., NCERT. 5. Dr. N.N. Biswas, Dy. Director (Trg.) 6. Dr. A.K. Jallaludin, Director, Dte. of Adult Education. <i>Chairman</i> : Dr. I.D. Bajaj, Addl. D.G., D.G.H.S.
	11.30 - 11.50 hrs.	: Tea / Coffee Break
	11.50 - 13.00 hrs.	: Group Work
	13.00 - 14.00 hrs.	: Lunch Break
	14.00 - 15.00 hrs.	: <i>Plenary Session 2</i> Review of behavioural research in health and health education, future strategy. 1. Dr. N.R. Parthasarathy, Jt. Director,

Backward Classes Commission.

2. Dr. A.B. Hiramani, D.D.(R.) CHEB.  
*Chairman* : Dr. Ashish Bose, Director,  
Institute of Economic Growth.

15.00 - 15.15 hrs. : Coffee Break

15.15 - 16.30 hrs. : Group Work

16.30 - 17.00 hrs. : Meeting of Conference Committees.

February 28, 1980 9.30 - 10.00 hrs. : Report of Conference Committees.

10.00 - 11.30 hrs. : *Plenary Session 3*

**Scope & Utilization of various types of media in health education.**

1. Sh. V.N. Kakar, Chief (Media)

2. Sh. V.K. Mathur, Dy. Dir. Gen.,  
All India Radio.

3. Km. Sipra Ray, Dy. Dir. Program-  
mes, Doordarshan.

4. Sh. T.K. Parthasarathy, Editor,  
CHEB.

5. Sh. K. Balasubramanyam, Technical  
Officer, CHEB.

*Chairman* : K.S. Srinivasan  
Director, Press Commission of India.

11.30 - 11.45 hrs. : Tea/Coffee Break

11.45 - 13.00 hrs. : Group Work (*Contd.*)

13.00 - 14.00 hrs. : Lunch Break

14.00 - 15.00 hrs. : *Plenary Session 4*

**Institutionalised Health Education  
Services / Primary Health Care—an  
Overview and future plans.**

1. Dr. B.C. Ghosal, Director, CHEB.

2. Dr. C.H. Piyaratna, Advisor (HE)  
WHO - SEARO.

*Chairman* : Dr. (Smt.) S. Chawla  
Principal, Lady Hardinge Medical  
College.

15.00 - 16.30 hrs. : Group Work (*Contd.*)

16.30 - 17.00 hrs. : Meeting of Conference Committees.



February 29, 1980      9.30 - 11.00 hrs.      : Report of Conference Committees.

10.00 - 11.30 hrs.      : Group Work, Finalising Reports.  
Tea and Coffee will be served in groups.

11.30 - 12.30 hrs.      : Presentation of Conference Reports.  
*Chairman* : Dr. B. Sankaran, Dir. Gen. of Health Services.  
Rapporteurs / Chairman of different groups.

12.30 - 13.30 hrs.      : Lunch Break

13.30 - 14.30 hrs.      : Modification and finalization of Reports.

14.30 - 15.30 hrs.      : *Valedictory Session*, Chief Guest Sh. P. Sabhanayagam, Secy., Ministry of Education & Culture.

14.30 - 15.30 hrs.      : Welcome Address : Dr. R. Sen, DDG (P)  
Conference Report : Participant  
Remarks : Participant  
Valedictory Address : Shri Sabhanayagam.  
Chairman's Address : Dr. I.D. Bajaj.  
Vote of Thanks : Dr. B.C. Ghosai

Tea/Coffee with the Chief Guest

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## GUIDELINES FOR GROUP WORK

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There will be four groups on the following areas :

1. Health Education Specialists.
2. Health Professionals.
3. Community Health Education which includes Health Education Bureaux both at Central and the State Levels.
4. School Health Education

Group 1 will concentrate its attention on the strengthening of the training programme for preparing health education specialists, *i.e.*, Diploma in Health Education Course.

Group 2 will lay emphasis on the training programme for preparing Health Professionals such as Doctors, Nurses, Sanitarians, Health Workers, Community Health Volunteers, etc.

Group 3 will confine its attention to the education of the community to reach health for all by 2000 A.D. This group will consider the functioning of the Health Education Bureaux both at the Central and State levels engaged in public health education.

Group 4 will concentrate on school health both through formal and non-formal systems of education (pre-school to college level).

### GUIDELINES

Each group will concentrate its work on the following :

- (a) The present set-up;
- (b) Curriculum;
- (c) Pre-service and Programme of Continuing Education;
- (d) Research/Studies needed for Programme Development;
- (e) Teaching Aids; and Communication Support.

Each group will work out a health education strategy covering all the points mentioned above keeping in view the goal 'HEALTH FOR ALL BY 2000 A.D.'

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## LIST OF BACKGROUND PAPERS FROM SPEAKERS

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1. Review of Diploma in Health Education Courses in India and Scope for further Modifications.  
—*Dr. Lois Philip*  
—*Dr. V.S. Chauhan.*
2. A Strategy — Health Education in Urban Municipal Set-up (Tamil Nadu)  
—*Sumathi S. Rao*
3. Review of Health Education Component in Medical Education (current status & scope for further development).  
—*Dr. Harcharan Singh*  
Medical College, Patiala.
4. Status of Health Education, Tamil Nadu.
5. A set of educational and other relevant material from U.P.
6. OPCAR Foundation.
7. Linkages between H.E. & Adult Education.  
—*A.K. Jalaluddin*
8. NCERT Experience of Developing Health Education in the efforts of N.C.E.R.T.  
—*Dr. Ganguly, Banka B.*
9. Health Care in Rural Areas-Rural Health Programme in India.  
—*Dr. B.C. Ghosal*
10. Primary Health Care in India.  
—*Dr. B.C. Ghosal*
11. Training on Health Education of Medical Students.  
—*Dr. P.V. Gulati of LHMC*
12. Review of Health Education Component in the Nursing Education, Current Status and Scope for further Modification/Areas of Strengthening.
13. Work Report of Activities of Health Education for 1979 in Delhi Corporation.  
—*T.R. Bhasin, HEB, Municipal Corporation of Delhi.*

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## LIST OF BACKGROUND PAPERS FROM CHEB

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1. Code of ethics for Health Educators.
2. Community Participation for Better Health — *Dr. V. RamaKrishna.*
3. Alma-ata declaration.
4. Primary Health Care in India — *Dr. B.C. Ghosal.*
5. National Medical Education Policy.
6. How to interest people in things they don't want to know.
7. Review and Development of Health Education Organisation at different levels — Present position of Development of Health Education in States/U.T. at a glance — *Dr. S.A. Pandit.*
8. Rural Health Services in India — *Dr. B.C. Ghosal.*
9. Some examples of Practical Approaches to Health Education.
10. Introducing Central Health Education Bureau.
11. Summary of the important Recommendations of the School Health Committee.
12. Status of Health Education in India.
13. Integration of Health Education in Medical Curriculum.
14. Community Health Volunteers Scheme — *Dr. B.C. Ghosal.*
15. School Health Education in India — *Shri J.S. Manjul.*